Family Medicaid Integrated

Participant Guide

August 1, 2009

Family Medicaid

Participant Guide

INTRODUCTION

Objectives

☐   Participants will demonstrate familiarity with surroundings, other participants, and overall focus of training.

☐   Participants will understand the standards, expectations, and attendance policy for the training course.

☐   Participants will discuss the DHS Mission, Values and Goals.

☐   Participants will discuss the focus of DFCS and doing the Right Work the Right Way.

☐   Participants will understand their responsibilities as mandated reporters of child abuse/neglect and adult abuse/neglect.

☐   Participants will be introduced to seven concepts/areas of concern that may serve as red flag warnings of possible child abuse and/or neglect.

☐   Participants will be introduced to several initiatives that promote collaboration between the Office of Family Independence (OFI) and Social Services sections.

☐   Participants will become familiar with common abbreviations used in the Family Medicaid program and in SUCCESS.

☐   Participants will understand the need for absolute confidentiality in the work that they will do.

Outline

I.   Introduction

II.   Format of Training

III.   Training Overview

IV.   Training Information

V.   Standards, Expectations, and Attendance Policy

VI.   DHS Mission, Values and Goals

VII.   Mandated Reporting of Abuse or Neglect of Children (MR 2015)

VIII.   Mandated Reporting of Adult Abuse or Neglect

IX.   Confidentiality and HIPAA (MR 2010 and 2011)

15 DAY OUTLINE
FAMILY MEDICAID
INTEGRATED TRAINING

DAY 1
Introduction
Customer Service
SUCCESS Medicaid Overview

DAY 2
SUCCESS Medicaid Overview
Application Processing

DAY 3
Application Processing
Newborn Medicaid
Low Income Medicaid

DAY 4
Low Income Medicaid

DAY 5
Low Income Medicaid

DAY 6
Low Income Medicaid

DAY 7
Low Income Medicaid
Skill Demonstration Review
Policy Review for Exam I

DAY 8
Exam I
SUCCESS Skill Demonstration Part One

DAY 9
Case Management
Transitional Medical Assistance

DAY 10
Transitional Medical Assistance
Four Months Extended Medicaid

DAY 11
Right from the Start Medicaid

DAY 12
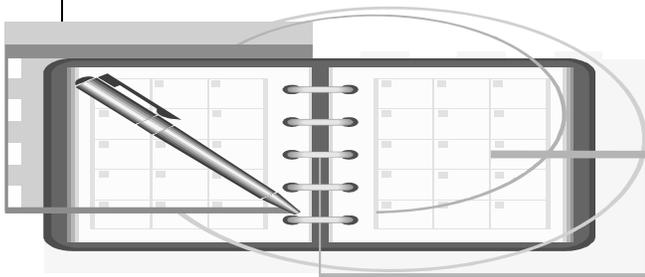Right from the Start Medicaid

DAY 13
Continuing Medicaid Determination
Emergency Medical Assistance
Reviews

DAY 14
Reviews
Skill Demonstration Review
Policy Review for Exam II

DAY 15
Exam II
SUCCESS Skill Demonstration Part Two
Closing

Overview of Topics Trained in
Family Medicaid Integrated Training

Day 1

Introduction – This module provides participants with an introduction to the trainer and other participants; basic information about the facility; the format of training; a discussion of expectations; the mission, values and goals of DHS; the focus of DFCS in doing the Right Work the Right Way; information on their responsibilities as mandated reporters of child abuse or neglect and adult abuse or neglect; seven areas of concern that may be red flag warnings of possible abuse or neglect; and several initiatives that are promoting collaboration between DFCS OFI and Social Services Sections.

Customer Service – This module focuses on the necessity of providing good customer service to the families we serve. Tips for effectively conducting interviews, whether by phone or in person, are provided.

SUCCESS Medicaid Overview – This module provides participants with a basic overview of the Medicaid program and navigation of the SUCCESS computer system. The Family Medicaid Classes of Assistance and the Continuing Medicaid Determination process are briefly discussed. The Classes of Assistance for Aged, Blind and Disabled individuals are reviewed with emphasis on the Katie Beckett and NOW/COMP Classes of Assistance. A brief overview of the Multi-Health Net system and Medicaid issuance is also provided.

Day 2

SUCCESS Medicaid Overview – Continued

Application Processing – The Application Process is covered including forms to be completed at initial application, interview requirements, and Standard of Promptness procedures. The process for entering an application in the SUCCESS computer system is also covered. A sample application Form 297/297A/297M is provided along with the process for printing an Application for Assistance (AFA) through the SUCCESS computer system. Additionally, reference is made in the Participant Guide for information on Non-Emergency Transportation Procedures and the procedures for how to make referrals for the WIC and Health Check programs.

This module also covers the basic consideration and criteria for determining eligibility for Retroactive Medicaid. Additionally, the budgeting and verification requirements are discussed.

Day 3

Application Processing – Continued

Newborn Medicaid (NB) – This module covers the basic policy criteria for determining eligibility for Newborn Medicaid.

Low Income Medicaid (LIM) – This module covers the basic non-financial and financial criteria for determining eligibility for a Low Income Medicaid initial application on SUCCESS. Reference is made to Clearinghouse to check for discrepancies.

- **Non-Financial** – covers the basic considerations and verification requirements for Age, Application for Other Benefits, Citizenship/ Alienage/Identity, Cooperation with Child Support Services, Living with a Specified Relative, Residency, and Third Party Resources.

- **Financial Resources** – covers the basic considerations and definitions of resources, the resource limit and how to determine whether or not the resource is countable. These commonplace types of resources are covered: Bonds, Cash, Checking Accounts, Credit Union Accounts, EITC, Equipment, Homeplace, Individual Development Accounts, Income Tax Refunds, Personal Goods, Saving Accounts and Vehicles. Verification of resources is also discussed.

- **Financial Income** – covers the basic considerations and definitions of income, whose income to include, whether or not the income is included, excluded, earned, unearned, and verification policy and procedures. The Medicaid Income Level chart is discussed. These common types of income are covered: Child Support, Contributions, EITC, Interest, Loans, Lottery Winnings, Pension/Retirement benefits, Social Security Benefits, Supplemental Security Income, Training Allowance, Unemployment Compensation, Veteran's Administration benefits, Wages, Wages of a child, and Worker's Compensation.

- **Budgeting** – covers the basic consideration and procedures for prospective budgeting along with the exceptions for using the conversion factors.

- **Deductions** – covers the $90, $30 & 1/3, Dependent Care and $50 Child Support deductions.

- **Notification** – covers providing adequate notice for initial Family Medicaid applications.

Day 4

Low Income Medicaid (LIM) – Continued

Day 5

Low Income Medicaid (LIM) – Continued

Day 6

Low Income Medicaid (LIM) – Continued

Day 7

Low Income Medicaid (LIM) – Continued

SUCCESS Review for Skill Demonstration

Policy Review for Exam I

Day 8

Exam I

SUCCESS Skill Demonstration Part One

Day 9

Case Management – This module covers the basic consideration and criteria for changes (financial and non-financial) that occur during an eligibility period, including what changes the AU/BG is required to report, the time frames for reporting changes, the verification requirements, how to process a change in SUCCESS, how to identify the effective month of change and how to identify the appropriate month a person will be added or deleted from an AU. Also included is the process for issuing a Temporary Medicaid card.

Transitional Medical Assistance (TMA) – This module covers the basic non-financial and financial criteria for determining TMA eligibility for the initial six months as well as the additional six month period. The processing of reported earned income changes and Quarterly Report Forms on SUCCESS is also discussed.

Day 10

Transitional Medical Assistance (TMA) – Continued

Four Months Extended Medicaid Because of Child Support (4MCS) – This module covers the basic policy and procedures for establishing an AU's eligibility for 4MCS. The processing of reported Child Support income on SUCCESS is also discussed.

Day 11

Right from the Start Medicaid (RSM) – This module focuses on the basic considerations and procedures for establishing Budget Groups and Assistance Units in RSM. The application process and the forms required for an RSM application are covered. The eligibility requirements for an RSM pregnant woman (RSM PgW) are covered including the RSM PgW income limit, the definition of pregnancy, the coverage period and Presumptive Eligibility.

The eligibility requirements for RSM children are covered including the income limits and coverage periods. The non-financial requirements for RSM are covered including Age, Citizenship/Alienage/Identity, Living Arrangements, Relationship, Enumeration, Application for Other Benefits, Residency, and Third Party Resources. Financial requirements are covered including determining countable income, budgeting procedures and applying the Medicaid deductions appropriately. Reference is made to Clearinghouse to check for discrepancies.

Medicaid options are covered including dual eligibility and when a child's income causes LIM ineligibility. A sample Form 94 for an RSM PgW application is reviewed. Additionally, this module covers how to identify a blended family and when to complete responsibility budgets.

Day 12

Right from the Start Medicaid (RSM) – Continued

Day 13

Continuing Medicaid Determination (CMD) – This module provides in-depth coverage of the process for completing a CMD for changes that impact an AU's eligibility.

Emergency Medical Assistance (EMA) – This module covers how to identify applicants who meet the criteria for Emergency Medical Assistance. How to determine if a Form DMA-526 is completed correctly is also discussed. The module also covers how to identify the correct SOP for an application processed through EMA. The steps to approve an EMA application and the procedures for how to identify the appropriate EMA coverage period are also covered. Chapter

2215 in the OFI Medicaid Policy Manual is referenced regarding DHS status and Web 1 VIS/CPS verification procedures for aliens, but no details are trained.

Reviews – This module includes the time frames for Reviews, the points of eligibility that must be re-established and the process by which SUCCESS identifies and schedules Reviews. The Case Manager's role in initiating and processing a Review on SUCCESS is also covered.

Day 14

Reviews – Continued

SUCCESS Review for Skill Demonstration

Policy Review for Exam II

Day 15

Exam II

SUCCESS Skill Demonstration Part Two

Closing

Course Evaluations

Training Information

TRAINING SCHEDULE: Training will begin at 9:00 a.m. and end at 4:00 p.m., with one hour for lunch and will include both morning and afternoon breaks. In addition to class time, the trainers are also available for one hour before and after class to answer questions. If multiple people need assistance, they will need to make an appointment with the trainer.

LEAVE POLICY: Please read the Education and Training Services Section Classroom Standards, Expectations and Attendance Policy.

You will be responsible for obtaining the material missed in the event of absence. If you have excessive absences, it may not be possible to complete the course.
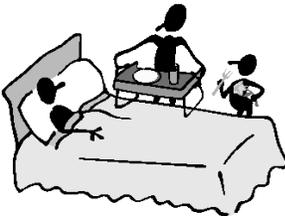
INCLEMENT WEATHER: In case of inclement weather, the decision of whether to hold training will normally be based on the facility where we are training.

If the weather is inclement in your area, please let your county and the trainer know that you will be absent.

FLSA TIME SHEETS: During training, the trainer will NOT sign your time sheets. Your county should have instructed you on completion. Please make sure you annotate all absences from training on your time sheet. Also, please read the memo FLSA Non-Exempt Employees Attending Required Training in your Participant Guide.
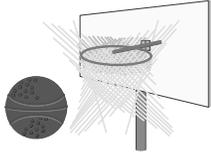
MATERIAL: During training, you will need the following materials:

- Family Medicaid Integrated Participant Guide
- Family Medicaid SUCCESS Handbook
- Pens
- Note pads
- Calculator
- Highlighter
- OFI Family Medicaid Policy Manual via ODIS

TRAINING AGENDA: Refer to the Outline of Training in the front of your Participant Guide.

GOALS FOR TRAINING:
- ❖ To learn the rules and regulations of the Family Medicaid Program.
- ❖ To be able to present the A/R with all Medicaid options.
- ❖ To be able to correctly establish eligibility for the Medicaid option chosen by the A/R.

TRAINING STANDARD:

An 80% overall grade average is required in order to pass the course.

EXAMS:
- ✧ There are two exams, which include a multiple-choice section and a forms-completion section.
- ✧ The exams are comprehensive, application oriented, and open-book. All resources, including the Participant Guide, notes, etc., may be used.
- ✧ The exams are timed. No exam will be accepted after the allotted time.
- ✧ There will be a review before each exam.
- ✧ Suggestions and study hints for taking an open-book exam are in your Participant Guide.
- ✧ Participants scoring less than 85% on an exam are expected to meet with the trainer.

EXAM DATES: _____   _____

SKILL DEMONSTRATION: The Family Medicaid SUCCESS Skill Demonstration will be administered in two parts on the same days as the exams. A numeric grade is not assigned for these assessments, however performance will be evaluated and feedback given to your County Director.

EVALUATIONS: A Final Evaluation will be sent to your County Director at the end of the training session.

A copy of this evaluation will be given/mailed to you as well. Refer to the sample copy of this evaluation in your Participant Guide.

UNSATISFACTORY PERFORMANCE: Your performance will be reported to the county as required and it will be their decision as to the action to be taken.

CLASS RULES: Refer to the Classroom Standards, Expectations, and Attendance Policy in your Participant Guide.

CERTIFICATES: Upon completion of the 15-day course, with at least an 80% score, you will be issued a certificate and awarded Continuing Education Units (CEUs) from the University of Georgia, School of Social Work. Your certificate will be mailed to your county office.

MEMO

Re: FLSA Non-Exempt Employees Attending Required Training
Page 1
May 1, 1995

The purpose of this memo is to provide further directions in reference to what is considered work time while attending required training.

The time spent in training is the actual hours training is in session. (For example: If training is from 9:00 a.m. to 4:00 p.m. with an hour for lunch, the actual work time is six hours.) Breaks are included as work time. However, lunch is not work time unless the employee is performing work during the lunch period. The fact that there is a planned luncheon does not necessarily mean that the lunch period is work time. A planned luncheon or reception after training is not work time unless the employee is specifically required to attend. Homework is not work time unless it's assigned. Trainers should designate a specific time frame for employees to do homework after class. (For example: The trainer ends class at 3:30 p.m. and states for the class to spend one hour after class reading the next day's assignment. This one hour is considered work time.)

Time spent to travel to training and back is considered work time regardless if the employee is driving or traveling with someone. The time it takes the employee to travel from home to the regular work site may be deducted.

FLSA is not concerned with work periods when less than 40 hours of work is performed. If hours spent in training, traveling to and from training and assigned homework add up to less than 40 hours, pay the full salary for that work period. Unless the employee habitually works less than 40 hours or the hours of work become a disciplinary matter, consider that the State requirement for a 40 hour week may be averaged over a three-month period. If the employee actually works over 40 hours in a work period after all adjustments for leave or time off are made, then overtime must be paid.

Time sheets should be kept by each employee attending training and signed by the employee and the employee's supervisor, not the trainer. The time sheet is an agreement between the employee and their supervisor, not the employee and trainer.

This information should be shared with all staff before they are required to attend training. If you have any questions regarding this matter, please contact the DFCS Employee Relations Unit.

RR: spa

cc: Joan Couch, Acting Chief
        Employee Development Unit - Human Services Section

SUGGESTIONS FOR STUDYING FOR AND TAKING TIMED OPEN-BOOK EXAMS

1.   Take notes in class to *supplement* material already in the Participant Guide.

2.   When working on exercises, complete **ALL** assigned. If you need additional emphasis, complete extra exercises and any not assigned in class.
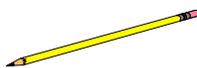
> Answer in pencil first, then in ink as class reviews the answers, or answer on a separate sheet of paper and use the questions again later as a study aid before exams.

3.   Review class notes and pertinent sections of the Policy Manual **DAILY.**

4.   Read Policy Manual sections relevant to topics covered in class notes. Become familiar with the location of these sections.

5.   **Review exercises** - Determine if the concept behind the question is understood.

6.   Study with others.

7.   Make arrangements with trainer to discuss areas which are still unclear.

8.   Study **DAILY** - do NOT cram the night before an exam!

9.   Study as carefully as you would for a closed-book exam.

10.   Manage your time wisely during the exam. Be aware of the total number of questions and/or forms to be completed. Assign yourself a general time frame for completing each section.

11.   Read each situation carefully; identify pertinent data which will help you make policy decisions.

12.   Read each question carefully.

13.   Read each multiple choice answer carefully.

14.   Eliminate any **OBVIOUSLY** incorrect answers.
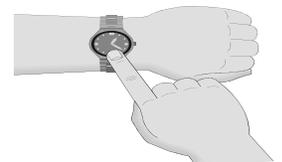
15. If you are unable to determine the correct answer, come back to it later. Sometimes another question will remind you of a policy concept. Sometimes you may want to refer to your manual or notes for clarification.

16. Once you have answered a question, do **NOT** change your answer unless you have **SOLID** evidence that you answered it wrong the first time.

17. Remember - the questions are designed to test your ability to identify data, relate it to a policy, and make a decision. Some answer choices may be correct in *another* situation. Look for the one which is correct for the *given* situation.

18. Be sure you have answered every question.

19. Be sure you have marked every question on your answer sheet.

20. If you have a different study method which has been successful for you, **USE IT!**
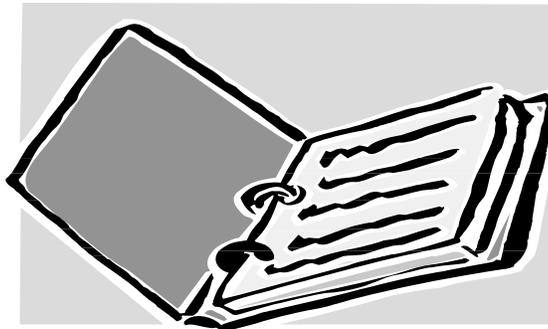
TO: _____, Director
     _____ County DFCS

FROM: _____, Training Specialist

DATE: _____

RE: Final Evaluation of Family Independence Case Manager
         Participating in Family Medicaid Integrated Training

Below is a training evaluation for _____, who
attended this session of the Family Medicaid Integrated Training. Please be sure
that the supervisor receives a copy of the evaluation. All workers who complete
the course and achieve an 80% course average will receive a certificate which
will be mailed directly to you in a few weeks.

Enclosed is a copy of a Training Summary Card that was developed by the
County Training Advisory Committee as a helpful tool for supervisors to
document and track training needs of their employees. It lists topics that are
either not covered in new worker training, or are covered briefly and need follow-
up training in the county. Should you have any questions about this evaluation,
please contact Lillie Gilchrist, Project Coordinator, at (706) 542-5465.

1 = Needs Improvement   2 = Meets Expectations

___   Understands the general purpose of the job.

___   Produces work of satisfactory quality.

___   Produces work of satisfactory quantity.

___   Displays appropriate organizational skills.

___   Uses time appropriately in class.

___   Is attentive in class.

___   Adheres to rules and policies of class.

___   Interacts appropriately with peers.

___   Interacts appropriately with trainer.

EXAM SCORES:

	CONTENT	**SCORE**
Exam I	Focuses on Application Processing, Retroactive Medicaid and Basic Financial and Non-Financial criteria for Newborn and Low Income Medicaid	_____
Exam II	Focuses on the above topics as well as TMA, 4MCS and RSM Classes of Assistance, Emergency Medical Assistance, Case Management and Reviews	_____

Final average of participant: _____

Final average of class: _____

ATTENDANCE:

<u>Dates Absent</u>   <u>Times</u>

COMMENTS:

Family Medicaid SUCCESS Skill Demonstration

The above-named participant completed a SUCCESS skill demonstration which incorporated the following actions in a Family Medicaid case, including documentation. Feedback is provided below:

SUCCESS ACTION	YES	NO
Action #1		
Action #2		
Action #3		
Action #4		
Action #5		
Action #6		
Action #7		

ADDITIONAL COMMENTS:

EDUCATION AND TRAINING SERVICES SECTION

DIVISION OF FAMILY AND CHILDREN SERVICES
TRAINING PROGRAMS

CLASSROOM STANDARDS, EXPECTATIONS
AND ATTENDANCE POLICY

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

August 23, 2006

Trainees are expected to dress in accordance with <u>Personal Appearance During Work Hours</u> per section IV of the DHS 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 DHS organizational units. In certain types of jobs, employees may be required to wear uniforms.*
>
> *DHS 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 DHS 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.

                                                                    August 23, 2006

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 _____

August 23, 2006

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 _____

Ask Your Supervisor

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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 portable drives 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.

THE DEPARTMENT OF HUMAN SERVICES
SERVICE MODEL

OUR MISSION:

To strengthen Georgia's families – supporting their self-sufficiency and helping them protect their vulnerable children and adults by being a resource to their families, not a substitute.

VALUES:

o   Do not accept welfare and total dependence on government for any family.

o   Expect adults to work.

o   Be a resource and support, not a substitute, for families.

o   Expect every consumer to invest/participate in their own recovery.

o   Serve people as close to home, family and community as possible.

o   Give customers as much control over getting the information they need as technologically possible.

o   Use data and information to help make decisions.

o   Do not accept "business as usual" – it's not good enough.

o   Spend government money like it's our own.

o   Treat customers as if they were our own family.

o   Make it faster, friendlier, easier for people to deal with us.

o   Reward our workforce for performance.

o   Deliver services as if we were not the only one who could do that work.

Goals of DHS/DFCS Staff

❖ **Working/Self-Sufficient Customers:**

Increase the number of DHS families achieving self-sufficiency through work or work-related activity.

❖ **Home/Community-Based Services:**

Increase the supply and use of home and community-based human services.

❖ **Technology Access:**

Increase customer and staff access to information that improves productivity.

❖ **Employee Engagement:**

Improve DHS employee engagement with customers.

❖ **Prevention:**

Increasing the number of Georgia citizens engaging in healthy, pro-social behavior.

DFCS Focus:
Develop Strong Families

Developing strong families means:

☑   Ensuring safety, permanency and well-being for Georgia's
       children

☑   Keeping kids safe

☑   Keeping kids happy, healthy and learning with families and in
       their communities

☑   Keeping adults providing for their families by working, weighing
       options and learning to effectively problem solve

☑   Keeping the elderly healthy and connected to life affirming
       activities.

The Right Work the Right Way

❖   Making our services faster, friendlier and easier to all
       Georgians

❖   Incorporating values into the work we do

❖   Building trust by showing genuine interest in learning about and
       understanding the family

❖   Engaging customers in the most effective and efficient way

❖   Focusing on the entire family unit to motivate, remove barriers
       and weigh options

❖   Empowering customers with options that will provide positive
       outcomes and produce movement in their lives to help
       strengthen their families

❖   Working in unison with Social Service Case Managers and
       other organizations to secure the support and resources
       needed by our families.

YOUR RESPONSIBILITY IN REPORTING CHILD ABUSE OR NEGLECT
(MR Policy Manual 2015)

ALL DFCS EMPLOYEES ARE REQUIRED BY LAW TO REPORT CHILD MALTREATMENT OR SUSPECTED ABUSE.

Even though your contact with a family may be limited to short office visits and telephone calls, you could observe or receive information that warrants a referral to child protective services.

ANY SUSPECTED ABUSE OR NEGLECT MUST BE REPORTED.

Your responsibility will be to report anything that you suspect is abuse. This includes but is not limited to the following:
  - observing physical signs (ex., bruises, black eye) on a child during an interview
  - observing abusive action during the interview
  - someone discloses information during the interview
  - someone discloses information during a telephone call

IF IN DOUBT, REPORT – ALWAYS ERR ON THE SIDE OF THE CHILD

CPS intake workers will screen all reports and determine whether to assign for investigation.

ALL REPORTS SHOULD BE MADE VIA TELEPHONE CALL AND FOLLOWED UP IN WRITING AS SOON AS POSSIBLE

If someone tells you of abuse during the interview or in a telephone call, connect them with the CPS intake unit at that time if possible. It is always best for the CPS worker to talk with the person who has the most knowledge. If you suspect the abuse, you need to call CPS. Always follow up in either situation with a Form 713 and route to CPS intake in your county. Keep a copy of the Form 713 for your record. If the child who is reported as being abused lives in another county, your CPS intake staff will follow up with notifying the correct county.

INCLUDE AS MUCH INFORMATION AS POSSIBLE IN THE REFERRAL

  - Child's name, age and address (and current location, if different from address)
  - Parent's name, address and telephone number
  - Reason for the referral (observation or information disclosed)
  - Reporter's name, address, telephone number and relationship to the problem.

IF SOMEONE ELSE DISCLOSES THE INFORMATION THAT WARRANTS THE REFERRAL, THEY DO HAVE THE RIGHT TO REMAIN ANONYMOUS

Collaboration Models

Family Preservation Services Pilot

The Family Preservation Services pilot was established in seventeen counties from around the state in order to develop and assess a new model for providing ongoing Child Protective Services (CPS). It was initiated in response to two pieces of data; families were involved with the CPS system longer than desired, and these same families had a higher than desired rate of recidivism into the CPS system. This data suggested that the current CPS practice model needed to be analyzed and possibly changed in order to more effectively attain positive outcomes for children and families.

The basis of the Family Preservation Model is in family centered practice and engaging community and family into our work. It incorporates Family Team Meetings and is focused on strengthening families by including them in the planning and decision-making process. Key elements and anticipated benefits of the new service delivery model include:

- Early and prompt assessment of family needs and risk issues

- Continuous assessment of risk throughout the life of the case

- Family focused Family Team meetings which identify strengths and resources early on

- Team approach engaging the family, OFI case manager, CPS investigator, Family Preservation case manager (CPS ongoing case manager) and community agencies

- Case Plan completion in less than 60 days, decreasing initial assessment time and focusing on goals to be completed and resources available

- Case Plan development with the family; focused on strengths and needs

- Community involvement leading to better relationships among agencies and more resources to families

- Informal support systems identified and engaged with the family; available to provide ongoing support once the case is closed

- Broad monitoring plan developed

- Key relatives identified early on as supports or as safety resources if needed

- Planned exit strategy (Discharge Plan) established with the family

- Time of agency involvement with the family potentially shortened. (Average length of Family Preservation Services: 4-5 months)

Family Resource Connection Pilot

The Family Resource Connection Pilot is being established in Regions VI and X in order to provide early intervention services to at-risk families receiving Food Stamp benefits and TANF. It was initiated in response to data indicating that both regions had a high percentage of Food Stamp cases that were also opened for ongoing child protective services. The data suggested that early assessment of risk, provision of short-term intervention and connections to family, community and agency resources might prevent later CPS involvement. Family Resource Specialists have been hired to screen Food Stamp applicants for voluntary participation in the Family Resource Connections pilot. Families participating in the pilot will receive supportive services from the DFCS Family Resource Specialist referrals to community resources.

Diversion

Diversion cases are those that may not immediately meet the criteria for a CPS investigation, but that indicate the family may need additional resources or support. Diversion workers initiate contact with the family, assess safety and risk, identify family needs, and provide appropriate services and referrals. Diversion cases are not investigations but can be reassigned as a formal investigation if more serious needs or potential risk are discovered. Diversion is an example of a collaborative model between Social Services and Office of

Family Independence. Both Social Services and OFI provide connections to community resources in order to assist families to prevent CPS involvement or the need to apply for OFI services. A work group including case managers and supervisors involved in diversion has been meeting to document the various models of diversion and best practices.

Family Team Meetings

Since the summer of 2005, the Division has embraced one model of structured Family Team Meetings (FTM) and has emphasized the importance of the Family Team Meeting process in all programs of the division….from child protective services to foster care to Office of Family Independence programs. Structured Family Team Meetings involve families and their personal resources in a manner which supports the family, ensures the safety of the child, and enhances the planning process. The meeting is different from any other type of family meeting or staffing done by DFCS; it is a structured meeting, and follows a sequence of stages lasting a total of 1.5 – 2 hours. The use of FTMs has proven to be effective in changing the entire dynamic of the relationship between child welfare professionals and families and can be utilized whenever a formal plan needs to be created (e.g., Case Plan) or a key decision made (e.g., potential relative placement), regardless of program areas.

Facilitating the Family Team Meeting requires an advanced skill set, especially group facilitation skills, and is led by a "DFCS Approved" FTM Facilitator, who has gone through an extensive training and coaching process. The FTM Facilitator is supported by a Co-Facilitator, who records key planning/decision making points on easel pads. The long-range goal is to have every Case Manager within these areas trained and approved as a Family Team Meeting Facilitator and competent in facilitating or actively supporting/participating in Family Team Meetings.

7 Concepts/Areas of Concern

Child Vulnerability
- Child under 4 years of age?
- Child physically or mentally impaired or in need of special care?

Caregiver Capability
- Does caregiver have significant impairment in mental capacity?
- Does caregiver have history of drug or alcohol abuse?
- Was caregiver abused or neglected as a child?

Quality of Care
- Has child been denied essential medical treatment?
- Is there overall lack of physical care?

Maltreatment Pattern
- Was any child addicted or exposed to drugs or alcohol?
- Has child suffered physical injuries or sexual abuse?

Home Environment
- Is the family experiencing any recent significant stress?
- Are the conditions in and/or around the home hazardous or unsanitary?

Social Environment
- Is the family socially isolated or unsupported by extended family?
- Has any person in the home ever been a victim of spousal abuse?

Response to Intervention
- Does any caregiver deny, seem unaware of, or take the allegations less seriously than CPS?
- Is any caregiver hostile toward or refusing to cooperate with CPS?

CPS Referral Situations

Situation 1: A customer comes in for her review and brings her two children with her. One is four and the other is six months old. Both children get restless during the interview and begin crying. The customer screams at the four year old to stop crying. You notice that he responds by screaming and shrieking back in terror. You observe bruises on his cheeks and his arms. The customer picks up the baby and shakes her roughly also telling her to be quiet. You notice also that there are bruises on the baby's legs.

Action to be taken: Try to calm down the customer and help with the children. Do not confront the customer about her inappropriate behavior. Call CPS intake immediately after the interview and follow up with a Form 713.

Situation 2: An absent parent for one of your customers calls you because your customer asked him to verify the child support he sends to her. He is angry and tells you he does not want his child receiving any public assistance because he provides for his child. He says if DFCS wants to do something they should give custody to him because he states your customer uses and sells drugs and is not providing a safe place for the child to live. The absent parent says his child (age 6) has called him numerous times asking to be picked up. When the absent parent got there your customer was "out of it".

Action to be taken: Encourage the absent parent to make the referral and transfer him to the CPS intake unit if he agrees to this. You will also need to call CPS intake. Then, follow up with a completed Form 713.

Situation 3: A mother and her three children come into your office. The mother says, "I cannot handle these kids any longer and I want you to take them!" The mother insists that DFCS take the children now. The client appears agitated and upset. She starts weeping and says she is sick. She says we must take the children.

Action to be taken: You alert your supervisor about the situation and then you call CPS intake to arrange for someone from Services to come right away and talk to the customer. Follow up with a Form 713.

PROTECTING CHILDREN

The Division of Family and Children Services at Work

Every child needs to be treasured, protected and nurtured. Unfortunately, some parents can't — or won't — care for their children. When they neglect or abuse them, some one must step in to ensure the children's safety. The community, the police, the courts and state and local agencies share this responsibility.

In Georgia, the Division of Family and Children Services (DFCS) has a special role as the state agency designated to protect children and strengthen families.

Many people misunderstand, or do not know, how DFCS does its job. Here is the way Georgia's Child Protective Services system (CPS) works.

Where do children go who must be removed from their homes?

If it is a crisis situation, the child may go to an emergency shelter. Then, about half of the children are placed with relatives and half with foster parents. DFCS evaluates all potential homes. Foster parents are screened and trained and receive financial aid to help with the cost of the child's care.

Is there more child abuse and neglect now than in the past?

After reaching all-time highs nationwide in the early 1990s, reports have decreased significantly. Many families whose problems are poverty-related (lack of adequate clothing, food or housing) are referred by DFCS to community resources for the help they need, so they do not enter the CPS system. This allows DFCS to address the cases where actual abuse and neglect have occurred and to concentrate its efforts on the most troubled families.

What rights do children have?

DFCS believes that children have the right to grow up in a stable home in a safe and healthy environment and not to be abused or neglected.

What happens if a child is still being neglected or is abused again?

If conditions do not improve, DFCS may go to court to seek temporary custody of the child. If custody is granted, DFCS places the child in a safe environment (for example, with a relative or foster family) while continuing to work with the parents to help them resolve their problems.

If the family does not improve, what is the next step?

DFCS petitions the court to terminate parental rights and make the child available for adoption.

Does Georgia emphasize keeping the family unit together at all costs?

No. The most important consideration is the safety and protection of the child. Both state and federal laws have set clear guidelines for quicker termination of parental rights in cases where families show no improvement and to ensure that children remain in foster care no longer than necessary. For example, when parents refuse or repeatedly fail to complete drug treatment successfully or do not follow improvement goals, DFCS is required to develop a permanency plan for their children and seek early termination and adoption.

DHR
GEORGIA
DEPARTMENT OF
HUMAN RESOURCES

If you think a child is being hurt or neglected whom do you call?

The Department of Family and Children Services is in every county. You simply call their local office and give them the name and location of the child. Your report is confidential. While you do not have to give your name to make a report, it can be more helpful for the child if you are willing to tell who you are and to testify in court if necessary. If you believe a child is in immediate danger, call the police. They will contact DFCS.

What is considered child abuse or neglect?

- Physical abuse is injury to a child under age 18 by a parent or caretaker which results in bruises, welts, fractures, burns, cuts or internal injuries.
- Neglect is the failure of the parent or caretaker to see that a child is adequately supervised, fed, clothed or housed.
- Sexual abuse occurs when a parent or other adult uses a child under age 18 for sexual stimulation.

What type of maltreatment is most reported?

Neglect makes up the bulk of the reports and the majority of substantiated cases. Lack of adult supervision is the most common type of neglect. Physical abuse is the next most reported and substantiated type of maltreatment, followed by sexual abuse.

What happens when you call DFCS to report suspected abuse or neglect?

The worker first determines whether the call is about the maltreatment of a child under 18 by a parent or caretaker. Reports that fall within these guidelines are investigated by DFCS investigators, frequently along with the police.

The law requires DFCS to notify the police of every report. About 60 percent of the reports received require an investigation. The remainder are referred to other agencies, such as the local police, health department or school system for assistance.

How soon after a report is made does the worker begin the investigation?

In-person response time ranges from within 24 hours to five days, depending on the nature of the allegation, the age of the child and the severity of the allegation.

What happens in an investigation?

Generally, the CPS worker

- checks other DFCS offices to see if there have been previous reports on this child or on the alleged perpetrator.
- visits the child at home or school to observe and talk with him or her directly.
- meets with the family to discuss the allegations.
- talks with anyone who may have information about the child and the family situation, including relatives, neighbors, friends, school personnel, and physicians.

The main concern throughout the investigation is the safety of the child.

Once an investigation is completed, how does the worker make a decision?

There are two possible outcomes of an investigation. The report is substantiated or unsubstantiated.

- Substantiated — means that more than half of the facts gathered indicate that the child has been abused or neglected.
- Unsubstantiated — means that there is not enough evidence to prove that the child has been mistreated.

If a report is substantiated, does DFCS automatically remove the child from the home?

No. A child may be taken from home by the police if he or she is in immediate danger. If there appears to be an ongoing risk to the child, DFCS may petition the juvenile court to remove the child.

Under what conditions may DFCS remove children who are not in immediate danger?

If the CPS staff determine that it is not safe for a child to remain at home (for example, when very young children are left home alone), then DFCS will file a petition with the juvenile court for a hearing to decide whether the agency will be granted temporary custody.

What happens to children who are left with their families after DFCS has confirmed abuse or neglect?

Families are rated as low-, moderate- or high-risk based on the nature and extent of their problems (substance abuse, no social support, violence). The most intensive services (more in-person visits by the case manager) are provided to the high-risk families as this has been shown to reduce repeat abuse and neglect. Case managers visit the family regularly and link them with other services to strengthen the family and address the causes of maltreatment.

What kinds of services are offered to these families?

- referral for alcohol and drug treatment
- referrals for employment and child support
- parenting education
- counseling
- in-home parent aides
- child care

ADULT PROTECTIVE SERVICES

All DFCS employees are required by law to report abuse, neglect or exploitation of disabled adults or elderly persons.

Calls that are Emergency Situations should be directed to contact 911.

Reports of abuse, neglect or exploitation of disabled adults or elder persons (**who are NOT residents of nursing homes or personal care homes**) should be directed to the **Adult Protective Services (APS) Central Intake Unit** of the Georgia Department of Human Services, Division of Aging Services.

APS Central Intake Unit Contact Information:

- Toll-Free: (888) 774-0152
- Within Metro Atlanta local calling area: (404) 657-5250

Reports of abuse, neglect or exploitation of disabled adults or elder persons **who live in a nursing home or personal care home** should be directed to the Georgia Department of Human Services, **Office of Regulatory Services or Long Term Care Ombudsman Program**.

Office of Regulatory Services Intake Contact Information:

- Toll-Free: (800) 878-6442
- Within Metro Atlanta local calling area: (404) 657-5728
- Submit a report online at http://aging.dhr.georgia.gov

Long Term Care Ombudsman Program Contact Information:

- Toll-Free: (888) 454-5826

Contact Information:

Division of Aging Services
Two Peachtree Street, NW
Suite 9385
Atlanta, Georgia 30303-3142

Phone: 404.657.5258
Fax: 404.657.5285

Family Medicaid

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.   Non-Verbal Communication

III.   Ten Rules for Providing Quality Customer Service

IV.   Positive Telephone Interviews

CUSTOMER SERVICE BEHAVIORAL STANDARDS

GREET your customers promptly and courteously.

LISTEN and verify your understanding of the customer's needs.
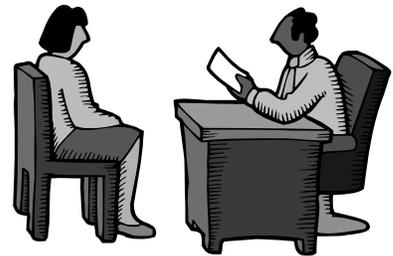
HELP customers with your answers and actions.

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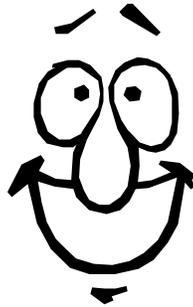
Open space: Don't put anything between you and the other person.

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…	DO NOT…
▪ Prepare for the call	▪ Have loud noises in the background
▪ Identify yourself to the customer	▪ Eat food or chew gum
▪ Tell the customer why you are calling	▪ Use DFCS jargon
▪ Ask for the individual with whom you would like to speak using their formal name	▪ Put the phone down/hang up the phone hard
▪ 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	

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.

Family Medicaid

Participant Guide

SUCCESS MEDICAID OVERVIEW

Objectives

☐   Participants will be able to identify limitations in the SUCCESS training region.

☐   Participants will be able to explain SUCCESS production region security.

☐   Participants will be able to sign on to the SUCCESS system.

☐   Participants will be able to navigate the SUCCESS system.

☐   Participants will be able to identify the use of the function keys in SUCCESS.

☐   Participants will be able to identify menu options from the AMEN screen.

☐   Participants will be introduced to the data screens in SUCCESS.

☐   Participants will be able to sign off of SUCCESS.

☐   Participants will be introduced to the various assistance programs available to the citizens of Georgia.

☐   Participants will be introduced to the different classes of assistance for Family Medicaid.

☐   Participants will briefly review the different classes of assistance for Medicaid for Aged, Blind and Disabled individuals.

☐   Participants will be introduced to the concept of Continuing Medicaid Determination.

☐   Participants will be introduced to the process of Medicaid Issuance.

Outline

ASSISTANCE PROGRAMS
AVAILABLE IN GEORGIA

TANF – Temporary Assistance for Needy Families provides assistance to needy families to help them become self-supporting through employment, pursuing child support and preventing out-of-wedlock pregnancies. Cash assistance is conditional upon compliance with work requirements and personal responsibilities. Families with children under 18 (and some 18 years) must be in financial need. This program is administered in Georgia by the Division of Family and Children Services (DFCS). A more detailed explanation of TANF follows this page.

SSI – Supplemental Security Income provides a monthly check and Medicaid to aged (age 65 or older), blind or disabled individuals who are in financial need. SSI may act as "supplement" to other income, or it may be the only income the individual receives. Disabled children may also receive SSI unless their parents have too much income. SSI is administered in all states by the Social Security Administration and funded entirely by the federal government.

GA – General Assistance provides assistance for disabled individuals not receiving SSI or families who are threatened with eviction. This is a county-funded program available only in certain counties in Georgia. Eligibility rules and types of assistance offered are different in each county. GA applications are processed by the county Division of Family and Children Services.

RRP – Refugee Resettlement Program provides cash, medical assistance, and social services for up to eight months to Refugee families who are in financial need based on TANF standards. The program is federally funded and administered in Georgia by the Division of Family and Children Services.

Energy Assistance provides financial assistance for low-income families to help pay for the cost of heating and cooling their homes. Energy Assistance is administered in Georgia by the Community Action Agencies. It is funded with money provided by the federal government and voluntary contributions to utility companies.

Medical Assistance Programs provides Medicaid to persons who meet certain requirements. Certain "Classes of Assistance" are listed and explained in the following pages. This is not a complete list.

MEDICAL ASSISTANCE PROGRAM

Family Medicaid Classes of Assistance

✻   **Newborn Medicaid (NB)** provides Medicaid coverage to a child born to a mother who was eligible for and receiving Medicaid under any class of assistance in Georgia on the day the child was born. A child is eligible for NB Medicaid for up to 13 months beginning with the month of birth and continuing through the month in which the child reaches age 1 as long as the child continues to live in Georgia.

✻   **Low Income Medicaid (LIM)** covers adults and children who meet the financial eligibility based on income and resource limits. In addition, LIM is available for families who choose to receive only Medicaid rather than cash assistance (TANF), or choose to receive their child support rather than TANF, or do not wish to comply with the Personal Responsibilities or the Work Requirements of the TANF Family Service Plan.

✻   **Transitional Medical Assistance (TMA)** provides Medicaid for up to 12 months to families for whom LIM is terminated because of increased or new earnings from employment. TMA uses 185% of the Federal Poverty Level as the income limit for eligibility. This program is to help transition families into full independence.

✻   **Four Months Extended Medicaid Because of Child Support (4MCS)** provides continued Medicaid eligibility when a LIM AU becomes ineligible for LIM because of the receipt of child support. The AU may receive four months of extended Medicaid.

✻   **Right from the Start Medicaid (RSM)** covers children and pregnant women who are not eligible for LIM. Eligibility covers pregnant women who have income less than or equal to 200% of Federal Poverty Level (FPL), children under age 1 who have income less than or equal to 185% of the Federal Poverty Level (FPL) and children from age 1 through 6th year birth month who have income less than or equal to 133% of FPL. It also covers children age 6 through age 18 who have income less than or equal to 100% of the Federal Poverty Level. This program was created to help reduce infant mortality in the U.S. and to give young children the "right start" in life. It allows many families the safety net of medical coverage for children while they continue to financially support themselves.

❋ **Medically Needy Medicaid (MN)** provides Medicaid to children and pregnant women who cannot qualify for Medicaid any other way. This program allows the family to "spenddown" excess income with their medical expenses as a means of becoming Medicaid eligible. It provides support for the working family which has too much income to be eligible for RSM but also has high medical bills. This class of assistance will not be covered in this training session.

❋ **Child Welfare Foster Care Medicaid (CWFC)** provides Medicaid coverage for a child who is in placement for whom DFCS has partial or total responsibility and who also has been determined ineligible for IV-E Foster Care. Eligibility for CWFC Medicaid is based on LIM basic eligibility requirements with some exceptions and LIM income and resource requirements. This class of assistance will not be covered in this training session.

MEDICAL ASSISTANCE PROGRAM
Aged, Blind, or Disabled Medicaid Classes of Assistance

✳   **"Public Law" Medicaid** can continue Medicaid coverage for individuals who had previously been eligible for Medicaid due to receipt of SSI, but who became ineligible for this program, and consequently became ineligible for Medicaid, due to either an initial entitlement to Retirement, Survivors, Disability Insurance (RSDI) or an increase in RSDI.

✳   **Institutionalized/Home-Based Program** covers aged, blind or disabled persons who are in an institution or home-based program for 30 continuous days. This program uses an income limit that is 3 times the Supplemental Security Income (SSI) limit. It includes individuals in a hospital or nursing home as well as other individuals.

> **Hospital Medicaid** covers aged, blind or disabled persons who are in a hospital for 30 days or in a nursing home. This program uses an income limit that is 3 times the SSI income limit.
>
> **Hospice Care Medicaid** provides Medicaid to terminally ill persons who wish to receive services at home or in a Medicaid participating nursing home from a hospice care provider. This type of Medicaid uses the same income and resource limits as listed above.
>
> *Katie Beckett Medicaid provides Medicaid to blind or long-term disabled children at risk of entering an institution. This Medicaid coverage allows the child to be cared for at home rather than having to enter a nursing home. To determine eligibility for Medicaid under Katie Beckett, consideration of the parents' income and resources is "waived". Only the **child's** monthly income and resources are considered.*

✳   **"Waiver" Classes of Assistance** provides additional services above what regular Medicaid pays. Each program defines what expenses are covered.

> **Community Care Services Program Medicaid (CCSP)** provides coverage to persons who wish to receive treatment under the Community Care Services Program at home rather than enter a nursing home.

New Option Waiver (NOW) and Comprehensive Supports Waiver Program (COMP) are designed to provide in-home and community-based services to Medicaid eligible mentally retarded and developmentally disabled individuals who do not receive Medicaid benefits under a cash assistance program.

Independent Care Waiver Program (ICWP) provides Medicaid for individuals who meet criteria for Nursing Home placement, but remain at home. These individuals are severely physically disabled or have traumatic brain injuries. These individuals need more care than can be provided by CCSP.

✳ **Q-track Classes of Assistance** provide limited benefits to Medicare eligible individuals.

Qualified Medicare Beneficiaries (QMB) acts as a medical coverage supplement to persons on Medicare. The income limit is 100% of the Federal Poverty Level (FPL) and the resource limit is twice the SSI limit. QMB pays the Medicare premium, deductible, and co-payment for Medicare recipients.

Specified Low-Income Medicare Beneficiary (SLMB) is a class of Medicaid assistance that pays the monthly premium for Medicare Supplemental Medical Insurance (Part B) for individuals who meet certain financial criteria, but whose income or resources make them ineligible for Medicaid.

Qualifying Individuals 1 (QI-1) is a class of assistance that pays the monthly premium for Medicare Supplemental Medical Insurance (Part B) for individuals who meet financial criteria based on a percentage of the FPL. The eligibility criteria are identical to SLMB except that the coverage is time-limited depending on available State funds and the income limit is higher than the SLMB limit.

✳ **ABD Medically Needy Medicaid (AMN)** provides Medicaid for the aged, blind or disabled who cannot qualify for Medicaid any other way. This program allows the individual or family to "spenddown" excess income with their medical expenses as a means of becoming Medicaid eligible.

MEDICAID GENERALLY COVERS THE FOLLOWING:

✓ Inpatient hospital services with the following restrictions:
  - ✗ one daily physician's visit
  - ✗ one pre-operative in-patient day
  - ✗ no reimbursement for Friday, Saturday or day-before-holiday admissions, except for emergencies

✓ Outpatient services with the following restrictions:
  - ✗ visits must be medically justified
  - ✗ services are limited to hospitals with organized outpatient clinics

✓ X-ray and laboratory services

✓ Prescriptions, drugs and supplies with the following restrictions:
  - ✗ 6 prescriptions per child per month and 5 prescriptions per adult per month unless the physician receives pre-approval from DMA for more than the limit
  - ✗ drugs must be on the approved list authorized by DMA
  - ✗ AUs must use the same pharmacy throughout the month for all individuals listed on the Medicaid card

✓ Physician's services with the following restrictions:
  - ✗ 12 physician office visits per AU member per fiscal year
  - ✗ services necessary for the diagnosis or treatment of illness or injury
  - ✗ family planning services; limited to two per AU member per fiscal year
  - ✗ voluntary sterilization
  - ✗ Healthcheck services for individuals under 21
  - ✗ Vaccinations only if directly related to treatment of an injury or direct exposure

✓ The charge for Supplementary Medical Insurance for those eligible for Medicaid and Medicare

✓ Emergency Ambulance services

✓ Orthotic/Prosthetic services

✓ Whole blood

✓ Limited Psychological services

✓ Limited dental services

NOTE: The above list is not all-inclusive. The Medicaid provider has a comprehensive list of services covered by Medicaid.

CMD Order
Family Medicaid

Newborn

LIM

TMA   **4MCS**

RSM

PeachCare for Kids

Medically Needy

Department of Community Health

The Department of Community Health is the federally recognized Medicaid Authorizing Agency for Georgia. They are in charge of all the Medicaid for the state of Georgia. They contract out with many different agencies and companies to perform all of the many needed functions with Medicaid. Medicaid eligibility, by federal law, must be determined by either the Medicaid Authorizing Agency (DCH) or the Title IV-A Agency (DFCS). Georgia chose to have Medicaid eligibility determined by DFCS.

Department of Family and Children Services	Social Security Administration	Policy Studies, Inc.
Completes all Medicaid eligibility determinations offered in Georgia except for the initial SSI Medicaid determinations.	Completes initial SSI Medicaid determinations based on federally approved option.	Completes PeachCare for Kids Medicaid applications.

Multi Health Net
www.ghp.georgia.gov

The Multi Health Net is the main consolidated computer system that displays all customers on Medicaid and what class of assistance they are receiving. It also displays any third party insurance. This is the system that providers interface with to submit billing requests, authorizations for treatment, etc. The MHN system receives data from agencies such as SSA, DFCS and PSI. It generally takes approximately two days for the data to reach the MHN system. In the event that the data does not display by the second day, review **Appendix C – Medicaid Issuance** in the Online Policy Manual at www.odis.dhr.georgia.gov.

Family Medicaid

Participant Guide

APPLICATION PROCESSING

Objectives

☐   Participants will be able to identify the application process for Family Medicaid.

☐   Participants will be able to identify Medicaid application forms.

☐   Participants will be able to identify non-DFCS agencies that accept Family Medicaid applications.

☐   Participants will be able to screen an applicant on SUCCESS.

☐   Participants will be able to register an application on SUCCESS.

☐   Participants will be able to print an Application for Assistance.

☐   Participants will be able to apply the appropriate standards of promptness for Family Medicaid Classes of Assistance.

☐   Participants will be able to determine eligibility for Retroactive Medicaid.

☐   Participants will be able to complete a Prior Months application in SUCCESS.

☐   Participants will be able to enter appropriate documentation.

☐   Participants will be able to determine the appropriate notification for an initial application.

☐   Participants will be able to identify referrals appropriate for Medicaid families.

Outline

OVERVIEW OF THE APPLICATION PROCESS

**Application screened
and registered in
SUCCESS**

**Case Manager establishes
rapport and gathers information
using good interviewing skills**

**Verification
returned**

**Case Manager requests
verification as needed**

**Information from the interview
is entered in SUCCESS**

**Verification entered and
the application is
processed in SUCCESS**

**SUCCESS processes
the information in
overnight batch**

**SUCCESS mails notice of
approval or denial**

**If approved,
benefits are issued**

Application Forms

94   Medicaid Application

222   Medicaid Review Form

297   Application for TANF, Food Stamps, or Medical Assistance

632W   Women's Health Medicaid Application

700   Application for Medicaid & Medicare Savings for Qualified Beneficiaries

PeachCare for Kids

Internet Medicaid Application

LISA – Low Income Subsidy Application

AFA – SUCCESS Application for Assistance

Women's Health Medicaid Review Form

A face-to-face interview is **NOT** a requirement of any Medicaid Class of Assistance (COA).

SUCCESS Registration

```
┌──────────┐   ┌──────────┐   ┌──────────┐
│   NAME   │───│   KIND   │───│   CIRC   │
└──────────┘   └──────────┘   └──────────┘

┌──────────┐ ┌──────────┐ ┌──────────┐ ┌──────────┐
│   MEMB   │─│   CRS    │─│   INCH   │─│   REDI   │
└──────────┘ └──────────┘ └──────────┘ └──────────┘
```
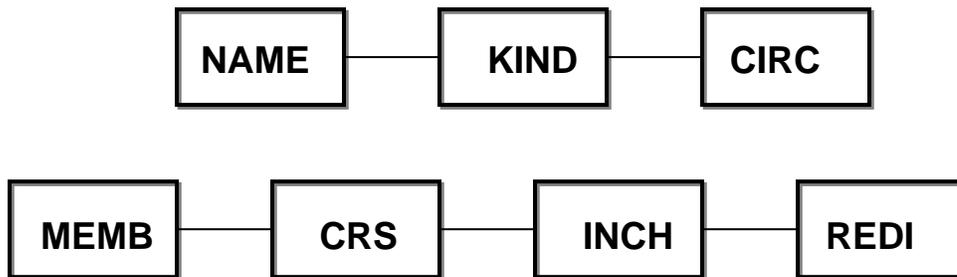
APPLICATION REGISTRATION – ANNA DAWSON
WALK THROUGH

Background

Mrs. Anna Dawson is applying for Medicaid for herself and her two children. Mrs. Dawson came into the office on 10/5/06 to complete the application form.

Your Assignment

- Screen each AU member

- Register Mrs. Dawson's application for Medicaid

- The trainer will walk through each of these screens and provide any additional information

AMEN

- Select A to begin the Screening process

- 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 0543
    0543 THIS DATA WILL BE WRITTEN TO THE DATABASE
```

CLIENT REGISTRATION SYSTEM

- Enter Mrs. Dawson's Social Security Number in SSN field

- Press ENTER

```
   HRRS0010              CLIENT REGISTRATION SYSTEM    CICSV2      10/05/2006
                            NAME/SSN INQUIRY                       09:09:15

   L NAME                 F NAME               M NAME         SFX
   SSN1 192 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






   92169 No Matches Found
   F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

CLIENT REGISTRATION SYSTEM

- Enter Dawson in L Name field

- Enter Anna in F Name field

- Enter U in Sex field

- Enter Mrs. Dawson's Race

- Press ENTER

```
   HRRS0010              CLIENT REGISTRATION SYSTEM     CICSV2     10/05/2006
                             NAME/SSN INQUIRY                      09:09:15

   L NAME  DAWSON            F NAME ANNA             M NAME          SFX
   SSN1 192 01 XXXX    DOB (MM DD YYYY)           +/-         SEX U    MORE

     RACE (Y/N)?: BLACK OR AFRICAN AMERICAN Y       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





   92169 No Matches Found
   F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

Note: Repeat this process for each AU member.

AMEN

- Select J to begin the Registration process

- 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 0543
    0543 THIS DATA WILL BE WRITTEN TO THE DATABASE
```

NAME

- Anna Dawson is the Head of Household

- Does not live in public housing

- Does not wish to register to vote

- Resides at 33 W. Magnolia Avenue, Savannah, GA 31419

- Phone number is 912-751-8232

- Receives mail at residential address

- Press ENTER

```
REGISTER                 APPLICANT NAME AND ADDRESS - NAME          NAME

CO 044 LO 049 Load ID XXXX      Client ID          Prev CO/LO    /
HOH F Name ANNA       MI     L Name DAWSON               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                           Line 2
Street   Number  Dir        Name            Type   City Dir    Apt
          33      W     MAGNOLIA               AVE
City SAVANNAH               ST GA   Zip 31419        Phone 912 751 8232

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

Message 0013    0156
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                      18-tbud
```

KIND

- Mrs. Dawson is applying for Family Medicaid

```
REGISTER              KINDS OF ASSISTANCE DESIRED - KIND          KIND


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




Message
                              18-tbud
```

CIRC

- Mrs. Dawson has unpaid medical bills in prior months

- 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 Y Any Unpaid Medical Bills Prior Month
  Medicare Entitlement                Community-Based Waiver
  Nursing Home                        Hospital
                                      Resident Battered Woman Shelter
  Migrant/Seasonal Farmworker         Refugee
  MA needed for adult with dep child  Authorized Rep



Message 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                18-tbud
```

MEMB – ANNA DAWSON

- Date of birth is 4/12/1976; verified by client statement

- Female

- SSN is 192-01-XXXX; verified by client statement

- Non-Latino

- Not pregnant

- Black

- Press ENTER

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

F Name ANNA        MI     L Name DAWSON             Suf
Relationship SE   DOB (MM DD YYYY) 04 12 1976   V CS   Sex F
SSA/SSN Appl For    SSN1 192 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 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                    18-tbud                     24-del


```

CRS – ANNA DAWSON

- Review potential matches

- Assign new client ID number

- Press ENTER

```
HRRS0070              CLIENT REGISTRATION SYSTEM    CICSV2    10/05/2006
                         NAME/SSN CLEARANCE                   15:02:48

CLIENT ID L NAME            F NAME      MI   DOB     SEX     SSN
000000001 DAWSON            ANNA          04 12 1976  F    192 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

F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

MEMB – ANNA DAWSON

- Enter Y in More Members field

- Press ENTER

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

F Name ANNA       MI    L Name DAWSON             Suf
Relationship SE   DOB (MM DD YYYY) 04 12 1976  V CS   Sex F
SSA/SSN Appl For    SSN1 192 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 Y



Message 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                  18-tbud                    24-del
```

MEMB – RANDY DAWSON

- Child

- Date of birth is 12/4/1995; verified by client statement

- Male

- SSN is 192-02-XXXX; verified by client statement

- Non-Latino

- Black

- Press ENTER

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

F Name RANDY         MI     L Name DAWSON            Suf
Relationship CH   DOB (MM DD YYYY) 12 04 1995   V CS   Sex M
SSA/SSN Appl For     SSN1 192 02 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 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                   18-tbud                  24-del
```

CRS – RANDY DAWSON

- Review potential matches

- Assign new client ID number

- Press ENTER

```
HRRS0070                    CLIENT REGISTRATION SYSTEM    CICSV2      10/05/2006
                              NAME/SSN CLEARANCE                       15:02:48

CLIENT ID L NAME            F NAME        MI    DOB     SEX     SSN
000000001 DAWSON            RANDY              12 04 1995  M    192 02 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

F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

MEMB – RANDY DAWSON

- Enter Y in More Members field

- Press ENTER

```
REGISTER                  HOUSEHOLD MEMBER – MEMB                 MEMB 01
                                                                      01
Client ID XXXXXXXXX        Del

F Name RANDY        MI    L Name DAWSON           Suf
Relationship CH   DOB (MM DD YYYY) 12 04 1995   V CS   Sex M
SSA/SSN Appl For    SSN1 192 02 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 Y


Message 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                              18-tbud                       24-del
```

MEMB – APRIL DAWSON

- Child

- Date of birth is 11/17/1998; verified by client statement

- Female

- SSN is 192-03-XXXX; verified by client statement

- Non-Latino

- Black

- Press ENTER

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

F Name APRIL        MI     L Name DAWSON              Suf
Relationship CH   DOB (MM DD YYYY) 11 17 1998    V CS   Sex F
SSA/SSN Appl For     SSN1 192 03 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 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                               18-tbud                        24-del
```

CRS – APRIL DAWSON

- Review potential matches

- Assign new client ID number

- Press ENTER

```
HRRS0070              CLIENT REGISTRATION SYSTEM    CICSV2    10/05/2006
                         NAME/SSN CLEARANCE                    15:02:48

CLIENT ID L NAME          F NAME     MI    DOB     SEX      SSN
000000001 DAWSON          APRIL         11 17 1998  F    192 03 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

F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

MEMB – APRIL DAWSON

- Press ENTER

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

F Name APRIL      MI     L Name DAWSON            Suf
Relationship CH   DOB (MM DD YYYY) 11 17 1998   V CS   Sex F
SSA/SSN Appl For     SSN1 192 03 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 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                    18-tbud                    24-del
```

INCH

- Enter Y in Indicate field for appropriate class of assistance

- Application date is 10/5/06

- Press F4 to bypass warning message

```
REGISTER                    INFORMED CHOICE - INCH                    INCH

HOH Name ANNA            DAWSON                  Client ID XXXXXXXXX
Indicate/add all programs the head of household wishes to apply for

   Ind      Program          Med COA          AU ID
   Y     MA MED ASST         F01



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

                         Appl Date 10 05 06


Message 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                        18-tbud         20-afa
```

REDI

- No appointment necessary

- Press F4 to bypass warning message

```
REGISTER              REGISTRATION DISPOSITION - REDI            REDI


HOH Name ANNA         DAWSON                  Client ID XXXXXXXXX


                         Withdrawal?


Sched Interview
              Unit Type 01                      Unit Supv 0989
              Inquiry Date 10 05 06              Load ID XXXX
              Appt Date ?                       Appt Type INT
   Appt Begin Time (HH:MM)   :        Appt End Time (HH:MM)   :
   L Name/Appt Remarks
   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
```

AMEN

- Write down the AU ID number on Form 353

```
                    ASSISTANCE UNIT/CLIENT SUBMENU - AMEN            AMEN

                         Selection J
              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 0543
   0543 THIS DATA WILL BE WRITTEN TO THE DATABASE
```

APPLICATION REGISTRATION – KELLY LANDON INDEPENDENT STUDY

Background

Ms. Kelly Landon is applying for Medicaid for herself and her son, Robert. She came into the office on 10/5/06 to complete the application form.

Your Assignment

- Review Ms. Landon's Medicaid application

- Screen each AU member

- Register Ms. Landon's application for Medicaid

- Request assistance from the trainer if needed

SCREEN

AMEN

- Select option A

- Press ENTER

CRS

- Enter Kelly Landon's data

- Press ENTER

- Press F2 to refresh

CRS

- Enter Robert Landon's data

- Press ENTER

- Press F3 to exit

REGISTER

AMEN

- Select option J

- Press ENTER

NAME

- Kelly Landon is Head of Household

- Does not reside in public housing

- Does not wish to register to vote

- Resides at 332 Peachtree Street, NE, Atlanta, GA 30308

- Phone number is 404-657-8989

- Mailing address is same as residential address

- Press ENTER

KIND

- Applying for Family Medicaid

- Press ENTER

CIRC

- Has unpaid medical bills for prior months

- Press ENTER

MEMB – KELLY LANDON

- Date of birth is 12/09/1970; verified by client statement

- Female

- SSN is 101-01-XXXX; verified by client statement

- Non-Latino

- Not pregnant

- White

- Press ENTER

CRS – KELLY LANDON

- Assign new client ID number

- Press ENTER

MEMB – KELLY LANDON

- More members in Assistance Unit

- Press ENTER

MEMB – ROBERT LANDON

- Child

- Date of birth is 3/10/1997; verified by client statement

- Male

- SSN is 101-02-XXXX; verified by client statement

- Non-Latino

- White

- Press ENTER

CRS – ROBERT LANDON

- Assign new client ID number

- Press ENTER

MEMB – ROBERT LANDON

- Press ENTER

INCH

- Select program code F01

- Application date is 10/5/06

- Press F4 to bypass warning message

REDI

- Press F4 to bypass warning message

AMEN

- Write down AU ID number on Form 353

Way to go!

CHART 2065.1 FAMILY MEDICAID FORMS							
FAMILY MEDICAID CLASSES OF ASSISTANCE	MANDATORY			CONDITIONAL			
	Application	*Form 216- Declaration of Citizenship/Alien Status See Appendix F, Forms	Form 5460-Notice of Privacy Practices (HIPAA)	Form 138 – Child Support Services (if child has NCP)	Form 285 – Third Party Liability (if TPL/TPR reported)	Form 297-A – Rights and Responsibilities (if application was made via Form 297)	Form 297-M Medicaid Addendum (if application was made via Form 297)
Newborn Medicaid (NB)							
Low Income Medicaid (LIM)	Y	Y	Y	Y	Y	Y	Y
Transitional Medical Assistance (TMA)		Y	Y		Y		
Four Months Extended Medicaid (4MCS)		Y	Y		Y		
Right from the Start Medicaid – Pregnant Woman (RSM-PgW)	Y	Y	Y		Y	Y	Y
Right from the Start Medicaid – Child (RSM-Child)	Y	Y	Y		Y	Y	Y
Family Medicaid Medically Needy (FM-MN)	Y	Y	Y	Y	Y	Y	Y
PeachCare for Kids (PCK)	Y	Y					

Standard of Promptness

10 Days

- **Pregnant Women**

- **Newborns**

45 Days

- **EMA – PgW**

- **All other COAS**
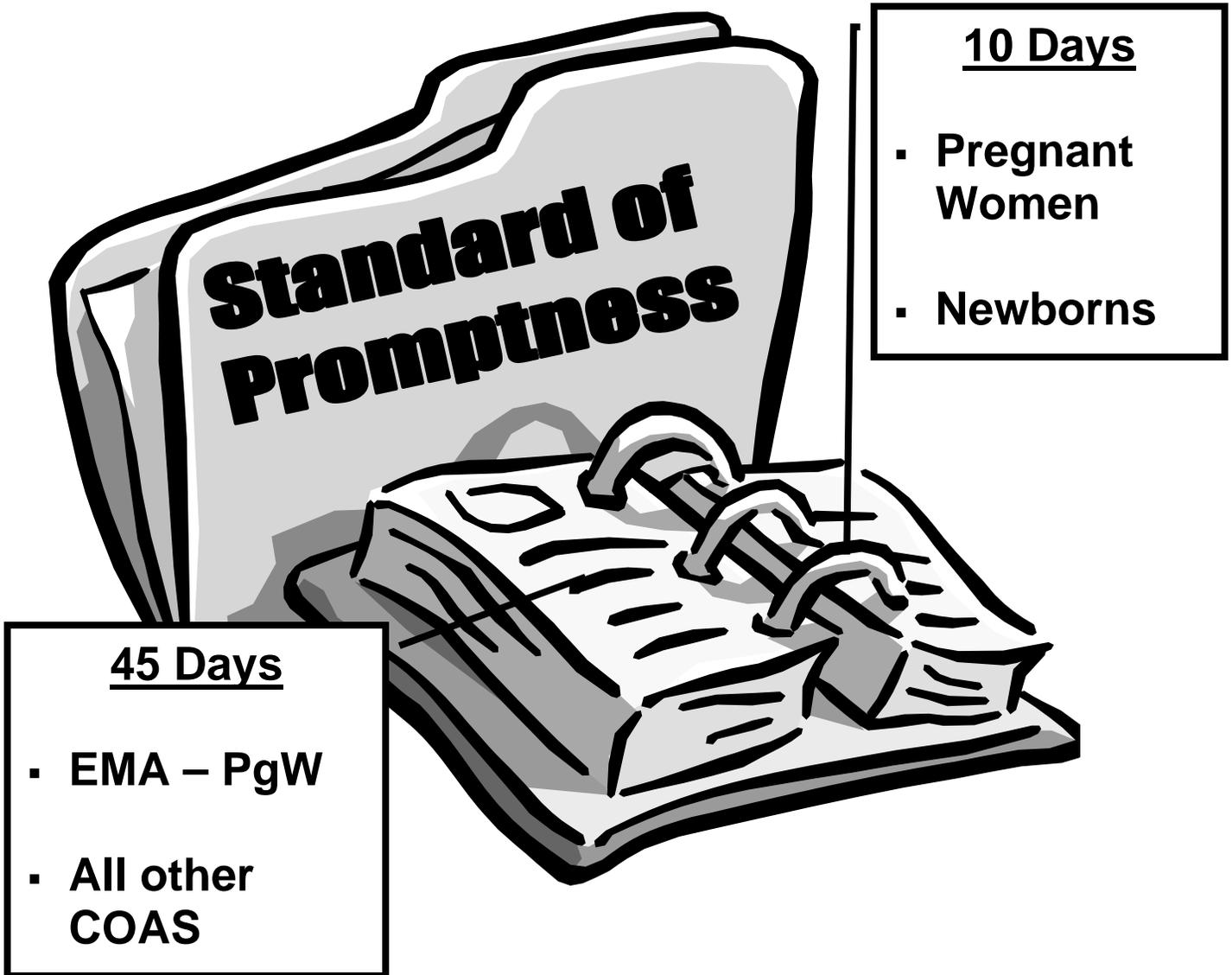
The count starts the day **of** application

If the SOP date falls on a weekend or holiday, complete the application by the last workday **prior to** the weekend or holiday.

July

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

August

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

September

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

October

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Prior Months

Retroactive Medicaid
(MR 2053)

Provides coverage for the following time periods:

◆ _____

◆ _____

Eligibility Criteria Not Required:

◆ _____

◆ _____

◆ _____

Budget:

◆ _____

◆ _____

◆ _____

*NOTE: For RSM-PgW cases, the A/R can be eligible for retroactive coverage without having an unpaid medical expense. However, the A/R must have been pregnant in the prior month for which coverage is requested.

PRIOR MONTH – SUSAN NELSON
WALK THROUGH

Background – Mrs. Nelson was approved for Medicaid for herself and her two children. Her household consists of herself, her husband Ralph and their two children. She has requested prior months Medicaid coverage for herself only for 8/06 and 9/06. She provides her check stubs for both August and September and states her family had no resources during that time. At the initial application, Mrs. Nelson reported no resources for her family.

Mrs. Nelson's wages are the household's only source of income. Her husband is not currently employed and takes care of the children while she works.

The Case Manager phones Mrs. Nelson at the phone number provided on her application in order to process her request for Prior Months Medicaid.
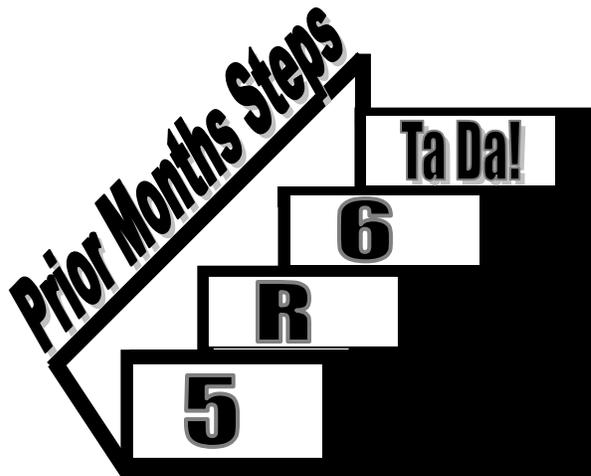
Blind Willies

Period End Date:	7/29/06	Employee Name	Susan Nelson	Employee ID	2351
Tax Status	2	Federal Allowance (From W-4)	4	Hours Worked	30.17
Hourly Rate	$7.25	Overtime Rate	$0.00	Sick Hours	0
Social Security Tax	$5.04	Federal Income Tax	$8.75	Vacation Hours	0
Medicare Tax	$0.98	State Tax	$5.03	Overtime Hours	0
Insurance Deduction	$0.00	Other Regular Deduction	$0.00	Gross Pay	$218.75
Total Taxes and Regular Deductions	$19.80	Other Deduction	$0.00	Total Taxes and Deductions	$19.80
Pay Date	8/5/06			Net Pay	$198.95

Blind Willies

Period End Date:	8/5/06	Employee Name	Susan Nelson	Employee ID	2351
Tax Status	2	Federal Allowance (From W-4)	4	Hours Worked	32.75
Hourly Rate	$7.25	Overtime Rate	$0.00	Sick Hours	0
Social Security Tax	$5.46	Federal Income Tax	$9.50	Vacation Hours	0
Medicare Tax	$1.07	State Tax	$5.46	Overtime Hours	0
Insurance Deduction	$0.00	Other Regular Deduction	$0.00	Gross Pay	$237.50
Total Taxes and Regular Deductions	$21.49	Other Deduction	$0.00	Total Taxes and Deductions	$21.49
Pay Date	8/12/06			Net Pay	$216.01

Blind Willies

Period End Date:	8/12/06	Employee Name	Susan Nelson	Employee ID	2351
Tax Status	2	Federal Allowance (From W-4)	4	Hours Worked	30.17
Hourly Rate	$7.25	Overtime Rate	$0.00	Sick Hours	0
Social Security Tax	$5.04	Federal Income Tax	$8.75	Vacation Hours	0
Medicare Tax	$0.98	State Tax	$5.03	Overtime Hours	0
Insurance Deduction	$0.00	Other Regular Deduction	$0.00	Gross Pay	$218.75
Total Taxes and Regular Deductions	$19.80	Other Deduction	$0.00	Total Taxes and Deductions	$19.80
Pay Date	8/19/06			Net Pay	$198.95

Blind Willies

Period End Date:	8/19/06	Employee Name	Susan Nelson	Employee ID	2351
Tax Status	2	Federal Allowance (From W-4)	4	Hours Worked	34.48
Hourly Rate	$7.25	Overtime Rate	$0.00	Sick Hours	0
Social Security Tax	$5.75	Federal Income Tax	$10.00	Vacation Hours	0
Medicare Tax	$1.13	State Tax	$5.75	Overtime Hours	0
Insurance Deduction	$0.00	Other Regular Deduction	$0.00	Gross Pay	$250.00
Total Taxes and Regular Deductions	$22.63	Other Deduction	$0.00	Total Taxes and Deductions	$22.63
Pay Date	8/26/06			Net Pay	$227.38

Blind Willies

Period End Date:	8/26/06	Employee Name	Susan Nelson	Employee ID	2351
Tax Status	2	Federal Allowance (From W-4)	4	Hours Worked	32.75
Hourly Rate	$7.25	Overtime Rate	$0.00	Sick Hours	0
Social Security Tax	$5.46	Federal Income Tax	$9.50	Vacation Hours	0
Medicare Tax	$1.07	State Tax	$5.46	Overtime Hours	0
Insurance Deduction	$0.00	Other Regular Deduction	$0.00	Gross Pay	$237.50
Total Taxes and Regular Deductions	$21.49	Other Deduction	$0.00	Total Taxes and Deductions	$21.49
Pay Date	9/2/06			Net Pay	$216.01

Blind Willies

Period End Date:	9/2/06	Employee Name	Susan Nelson	Employee ID	2351
Tax Status	2	Federal Allowance (From W-4)	4	Hours Worked	33.62
Hourly Rate	$7.25	Overtime Rate	$0.00	Sick Hours	0
Social Security Tax	$5.64	Federal Income Tax	$9.78	Vacation Hours	0
Medicare Tax	$1.08	State Tax	$5.71	Overtime Hours	0
Insurance Deduction	$0.00	Other Regular Deduction	$0.00	Gross Pay	$243.75
Total Taxes and Regular Deductions	$22.21	Other Deduction	$0.00	Total Taxes and Deductions	$22.21
Pay Date	9/9/06			Net Pay	$221.54

Blind Willies

Period End Date:	9/9/06	Employee Name	Susan Nelson	Employee ID	2351
Tax Status	2	Federal Allowance (From W-4)	4	Hours Worked	31.89
Hourly Rate	$7.25	Overtime Rate	$0.00	Sick Hours	0
Social Security Tax	$5.32	Federal Income Tax	$9.25	Vacation Hours	0
Medicare Tax	$1.04	State Tax	$5.32	Overtime Hours	0
Insurance Deduction	$0.00	Other Regular Deduction	$0.00	Gross Pay	$231.25
Total Taxes and Regular Deductions	$20.93	Other Deduction	$0.00	Total Taxes and Deductions	$20.93
Pay Date	9/16/06			Net Pay	$210.32

Blind Willies

Period End Date:	9/16/06	Employee Name	Susan Nelson	Employee ID	2351
Tax Status	2	Federal Allowance (From W-4)	4	Hours Worked	38
Hourly Rate	$7.25	Overtime Rate	$0.00	Sick Hours	0
Social Security Tax	$5.46	Federal Income Tax	$9.50	Vacation Hours	0
Medicare Tax	$1.07	State Tax	$5.46	Overtime Hours	0
Insurance Deduction	$0.00	Other Regular Deduction	$0.00	Gross Pay	$237.50
Total Taxes and Regular Deductions	$21.49	Other Deduction	$0.00	Total Taxes and Deductions	$21.49
Pay Date	9/23/06			Net Pay	$216.01

Blind Willies

Period End Date:	9/23/06	Employee Name	Susan Nelson	Employee ID	2351
Tax Status	2	Federal Allowance (From W-4)	4	Hours Worked	32.75
Hourly Rate	$7.25	Overtime Rate	$0.00	Sick Hours	0
Social Security Tax	$5.46	Federal Income Tax	$9.50	Vacation Hours	0
Medicare Tax	$1.07	State Tax	$5.46	Overtime Hours	0
Insurance Deduction	$0.00	Other Regular Deduction	$0.00	Gross Pay	$237.50
Total Taxes and Regular Deductions	$21.49	Other Deduction	$0.00	Total Taxes and Deductions	$21.49
Pay Date	9/30/06			Net Pay	$216.01

STEP ONE - 5

AMEN

- Select 5 to copy information to prior month(s)

- Enter Ms. Nelson's AU ID #

```
            ASSISTANCE UNIT/CLIENT SUBMENU - AMEN              AMEN

                        Selection 5
             AU ID XXXX00188          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

- Enter Y in Apply field next to appropriate month(s)

- Press ENTER

```
  UPDATE                 PRIOR MEDICAID COPY - PMCO           PMCO
                           5991   10 02 06

  HOH Name SUSAN       NELSON              Client ID XXXX00279
                   AU ID XXXX00188   Appl Date 10 01 06


           Apply      Benefit      AU         Med
                      Month        Stat       COA

                      07 06
             Y        08 06
             Y        09 06



  Message 0963
   0963 PLEASE SELECT RETRO MONTH(S) FOR DATA COPY
```

STEP TWO - R

AMEN

- Select R to update information

- Enter 08/06 in Benefit Month field

- Press ENTER

```
          ASSISTANCE UNIT/CLIENT SUBMENU - AMEN              AMEN

                     Selection R
           AU ID XXXX00188           Client ID
        Screen ID                    As Of Date
Benefit Month (MM YY) 08 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

- Press PF21 to access the NARR screen to enter documentation

- Prior month's coverage is requested and available for 8/06 and 9/06

NARR

- Document the following on NARR:

  TC – Ms. Nelson is requesting prior months Medicaid coverage for herself for 8/06 and 9/06. Ms. Nelson applied for Medicaid in 10/06. Coverage is available for 8/06 and 9/06. Ms. Nelson is the best source of information regarding her family's circumstances. Ms. Nelson provided her actual earnings for 8/06 and 9/06.

```
UPDATE                     NARRATIVE - NARR                    NARR
                                                                01

   10/05/2006 03:55 PM Family Medicaid Training
   TC – Ms. Nelson is requesting prior months Medicaid coverage for
   herself for 8/06 and 9/06.  Ms. Nelson applied for Medicaid in 10/06.
   coverage is available for 8/06 and 9/06.  Ms. Nelson is the best
   source of information regarding her family's circumstances.  Ms.
   Nelson provided her actual earnings for 8/06 and 9/06.




                                                                More
 MESSAGE

 13-bott
```

- Press ENTER to return to ADDR

ADDR

- Press the Home key to Fastpath to ERN2 for Susan Nelson

- Press PF4 to bypass warning message

ERN2 – SUSAN NELSON

- Change frequency code to Actual

- Enter actual income earned in 8/06

- Press the Tilde key to enter documentation

- Press the Home key to Fastpath to DONE

```
   CHANGE                   EARNED INCOME 2 - ERN2                    ERN2 01
   Month 08 06                                                        01

   Client Name SUSAN      NELSON                Client ID XXXX00279


   Employer Name BLIND WILLIE'S

                   Avg Hrs 37    Freq AC   Day Week Pd FR   Extra Pay

   Del

     Amt 1    V    Amt 2    V    Amt 3    V    Amt 4    V     Extra    V
    218.75   CH   237.50   CH   218.75   CH   250.00   CH
    ------------------------- 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
```

```
 UPDATE                      REMARKS - REMA                      REMA
                                                                 01
   ***************************** ERN2 CAL ****************************
   10/05/06 11:27 AM Family Medicaid Training
   APP(X)  REVIEW( )  NEW JOB ( )  RATE OF PAY ( )  HRS CHG ( )
   DATE OF CHANGE:_____ DATE OF REPORT:_____ TIMELY( ) UNTIMELY( )
   IF NEW EMPLOYMENT, RATE OF PAY/HOURS:_____
   EMPLOYER:BLIND WILLIE'S_____
    DATE PD     GROSS    TIPS      VERF    REP{Y/N}
   1:08/05/06  (218.75  ) (       ):CHECK STUB   (Y)
   2:08/12/06  (237.50  ) (       ):CHECK STUB_  (Y)
   3:08/19/06  (218.75  ) (       ):CHECK STUB_  (Y)
   4:08/26/06  (250.00  ) (       ):CHECK STUB_  (Y)
   5:_____  (        ) (       ):_____  ( )
   6:_____  (        ) (       ):_____  ( )
      TOTAL     :925.00__ /:4_____ = :231.25_____ REP PAY
   IF NOT REP, EXPLAIN:_____
   FREQ OF PAY  WK( ) BIWK( )  SEMIMTH( ) MONTHLY( ) ACTUAL(X)
   HR RATE:7.25_____
   CALCULATE Y/N ( )     CAL MONTHLY INCOME:925.00_____
                                                            More
 MESSAGE
 13-bott
```

DONE

- Press ENTER to commit to the database

AMEN

- Select R to update information

- Enter 09/06 in Benefit Month field

- Press ENTER

ADDR

- Press the Home key to Fastpath to ERN2 for Susan Nelson

- Press PF4 to bypass warning message

ERN2 – SUSAN NELSON

- Change frequency code to Actual

- Enter actual income earned in 9/06

- Press the Tilde key to enter documentation

- Press the Home key to Fastpath to DONE

```
CHANGE                    EARNED INCOME 2 - ERN2                ERN2 01
Month 09 06                                                           01

Client Name SUSAN        NELSON              Client ID XXXX00279

Employer Name BLIND WILLIE'S

                Avg Hrs 38    Freq AC   Day Week Pd FR   Extra Pay

Del

   Amt 1    V     Amt 2    V    Amt 3    V    Amt 4   V     Extra    V
  237.50   CH   243.75    CH   231.25   CH   237.50  CH    237.50   CH
   ------------------------   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
```

```
UPDATE                      REMARKS - REMA                   REMA
                                                               02
   ****************************** ERN2 CAL ******************************
   10/05/06 11:40 AM Family Medicaid Training
   APP(X)  REVIEW( )  NEW JOB ( )  RATE OF PAY ( )  HRS CHG ( )
   DATE OF CHANGE:_____ DATE OF REPORT:_____ TIMELY( ) UNTIMELY( )
   IF NEW EMPLOYMENT, RATE OF PAY/HOURS:_____
   EMPLOYER:BLIND WILLIE'S_____
     DATE PD    GROSS     TIPS      VERF    REP{Y/N}
   1:09/02/06  (237.50  ) (        ):CHECK STUB_   (Y)
   2:09/09/06  (243.75  ) (        ):CHECK STUB_   (Y)
   3:09/16/06  (231.25  ) (        ):CHECK STUB_   (Y)
   4:09/23/06  (237.50  ) (        ):CHECK STUB_   (Y)
   5:09/30/06  (237.50  ) (        ):CHECK STUB_   (Y)
   6:_____  (        ) (        ):_____   ( )
      TOTAL      :1187.50_ /:5_____ = :237.50_____ REP PAY
   IF NOT REP, EXPLAIN:_____
   FREQ OF PAY   WK( )  BIWK( )  SEMIMTH( ) MONTHLY( ) ACTUAL(X)
   HR RATE:_____
   CALCULATE Y/N ( )     CAL MONTHLY INCOME:1187.50_____
                                                          More
 MESSAGE 0019
 0019 UPDATE COMPLETED SUCCESSFULLY
 13-bott
```

DONE

- Commit to database

STEP THREE - 6

AMEN

- Select 6 to finalize

- Press ENTER

```
         ASSISTANCE UNIT/CLIENT SUBMENU – AMEN              AMEN

                        Selection 6
              AU ID XXXX00188           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

- Press ENTER

```
 UPDATE             FINALIZE PRIOR MEDICAID – FPME            FPME


 HOH Name SUSAN    NELSON              Client ID XXXX00279
 AU ID  XXXX00188

 Finalize

 Bnft      Status     Med    Spenddown    Disposition Status
 Month                COA     Amount

 08 06        P       P01                 WAITING FINALIZATION
 09 06        P       P01                 WAITING FINALIZATION




 Message
```

ELIG 08/06

- If correct, enter Y to confirm

- Press ENTER

```
FINALIZE            NON-FINANCIAL ELIGIBILITY RESULTS - ELIG        ELIG    A
Month 08 06                                                          01

 AU ID XXXX00188    Prog MA    Prog Type P    Med COA P01
 Confirm Y

  AU    AU Status  AU Stat   Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons    Date     Date    Date     Date     Type  End Date
  A                100506  100206  080106   08312006
 --------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl   --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date           Date    Date   Date    T  Date
 SUSAN  NEL   SE OT   Y    RE   A 100506        100206  080106 08312006
 RALPH  NEL   SP OT   Y    RP   A 100506        100206  080106 08312006
 BRENDA NEL   CH OT   Y    RP   A 100506        100206  080106 08312006
 MARCUS NEL   CH OT   Y    RP   A 100506        100206  080106 08312006




    Message
```

CAFI 08/06

- If correct, enter Y to confirm

- Press ENTER

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI           CAFI    A
Month 08 06
 AU ID XXXX00188    Prog MA   Prog Type P       Med COA  P01
                             Net Income Test (cont)
 Resources                      Standard - 30 1/3        90.00
   Resource Limit          .00  Dependent Care             .00
   Total Resources         .00  Net Earned Income       835.00
 Gross Income Test              Net Unearned Income        .00
   Gross Income Limit      .00  Deemed Income              .00
   Gross Earned Income  925.00  Allocated Income           .00
   Net Unearned Income     .00  Net Income              835.00
   Deemed Income           .00  Grant Amount               .00
   Allocated Income        .00  Recoupment Amount          .00
 Total Gross Income     925.00  Benefit Amount             .00
 Net Income Test                Previous Benefit           .00
   Net Income Limit     3900.00 Spenddown Amount
   Gross Earned Income  925.00  Medical Expense Amt
   Self Employ Work Exp    .00  Net Spenddown Amt
 Bnft Eff Date 100506 Bnft Confirm Y Reasons           Budgeting Method P
 Notice Type 0003         Waive Timely Ntc Period       Notice Override
  Review Begin Date 10 06   Review End Date 99 99        Strat 2
 Message

   13-note
```

ELIG 09/06

- If correct, enter Y to confirm

- Press ENTER

```
 FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG        ELIG    A
 Month 09 06                                                          01

 AU ID XXXX00188    Prog MA    Prog Type P    Med COA P01
 Confirm Y

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat   Reasons      Date      Date    Date     Date    Type  End Date
  A                  100506   100206   090106  08302006
 --------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn  Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp       Date     Date    Date   Date   T  Date
 SUSAN  NEL   SE OT   Y    RE   A 100506      100206  090106 09302006
 RALPH  NEL   SP OT   Y    RP   A 100506      100206  090106 09302006
 BRENDA NEL   CH OT   Y    RP   A 100506      100206  090106 09302006
 MARCUS NEL   CH OT   Y    RP   A 100506      100206  090106 09302006




 Message

```

CAFI 09/06

- If correct, enter Y to confirm

- Press ENTER

```
 FINALIZE           CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
 Month 09 06
 AU ID XXXX00188    Prog MA    Prog Type P       Med COA  P01
                              Net Income Test (cont)
 Resources                     Standard - 30 1/3      90.00
   Resource Limit         .00  Dependent Care           .00
   Total Resources        .00  Net Earned Income    1097.50
 Gross Income Test             Net Unearned Income      .00
   Gross Income Limit     .00  Deemed Income            .00
   Gross Earned Income 1187.50 Allocated Income         .00
   Net Unearned Income    .00  Net Income           1098.00
   Deemed Income          .00  Grant Amount             .00
   Allocated Income       .00  Recoupment Amount        .00
 Total Gross Income    1187.50 Benefit Amount           .00
 Net Income Test               Previous Benefit         .00
   Net Income Limit   3900.00  Spenddown Amount
   Gross Earned Income 1187.50 Medical Expense Amt
   Self Employ Work Exp   .00  Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y  Reasons        Budgeting Method P
 Notice Type 0003          Waive Timely Ntc Period     Notice Override
  Review Begin Date 10 06   Review End Date 99 99        Strat 2
 Message

   13-note

```

FPME

- Enter Y to finalize

CONGRATULATIONS YOU HAVE JUST COMPLETED PRIOR MONTHS MEDICAID!

PRIOR MONTH – KATHERINE NORWOOD
INDEPENDENT STUDY

Background – Ms. Norwood was approved for Medicaid for herself and her two children in October 2006. She has requested prior months Medicaid coverage for 8/06 and 9/06. Her wages from Wal-Mart are verified via The Work Number.

The Case Manager phones Ms. Norwood at the phone number listed in SUCCESS in order to process her request for Prior Months Medicaid.

Ms. Norwood further states she had cash of $15.00 and a checking account balance of $23.00 in August. Her resources for September included cash of $8.00 and a checking account balance of $65.00. She states she always maintains a balance of $50.00 in Joey's savings account. Ms. Norwood purchased her 1990 Toyota Corolla in 2004.

Ms. Norwood states she paid $10.00 each week on Fridays for Joey to attend Little Rascals Day Care Center.

Process Ms. Norwood's request for Medicaid coverage for the prior months indicated.

THE WORK NUMBER

Employment and Income Verifications

Social Service Verification

EMPLOYER
Employer: 90005 – Wal-Mart
Headquarters Address: 702 S.W. 8th Street
                                                              Bentonville, AR 72716

Federal Employer Identification Number (FEIN):   7654321
Division: BENTONVILLE

EMPLOYEE
Employee: KATHERINE NORWOOD
Social Security Number: 522-16-XXXX
Address: 879 Charter Blvd.
                                                              Macon, Georgia 31201

Employee Phone Number: Data not provided
Date of Birth: Data not provided

EMPLOYMENT
Employment Status: Active
Most Recent Start Date: 02/05/2006
Original Hire Date: 02/05/2006
Total Time with Employer: 8 Months
Job Title: CASHIER
Union Affiliation: Data not provided
Work Location (Job Site):   Data not provided

MEDICAL INSURANCE
Medical Coverage: No
Medical Carrier Name: N/A

DENTAL INSURANCE
Dental Coverage: No
Dental Carrier Name: N/A

VISION INSURANCE
Vision Coverage: No
Vision Carrier Name: N/A

WORKERS' COMPENSATION   -   Data not provided

INCOME AND DEDUCTIONS
Average Hours per Pay Period: 20
Rate of Pay: $6.55 / Hour
Pay Cycle: Week

	2006	2005	2004
Total Gross:	$4,120.00	$0.00	$0.00
Payroll Deduction for All Insurance Coverage:	$0.00		

PAY PERIOD DETAIL   -   Data not provided

HISTORICAL PAY PERIOD SUMMARY

Pay Period End Date	Pay Date	Hours Worked	Gross Earnings	Net
09/25/2006	10/02/2006	25	$128.75	$106.32
09/18/2006	09/25/2006	25	$128.75	$106.32
09/11/2006	09/18/2006	25	$128.75	$106.32
09/04/2006	09/11/2006	25	$128.75	$106.32
08/28/2006	09/04/2006	25	$128.75	$106.32
08/21/2006	08/28/2006	25	$128.75	$106.32
08/14/2006	08/21/2006	25	$128.75	$106.32
08/07/2006	08/14/2006	25	$128.75	$106.32
07/31/2006	08/07/2006	25	$128.75	$106.32
07/24/2006	07/31/2006	25	$128.75	$106.32
07/17/2006	07/24/2006	25	$128.75	$106.32
07/10/2006	07/17/2006	25	$128.75	$106.32
07/03/2006	07/10/2006	25	$128.75	$106.32
06/26/2006	07/03/2006	25	$128.75	$106.32
06/19/2006	06/26/2006	25	$128.75	$106.32
06/12/2006	06/19/2006	25	$128.75	$106.32
06/05/2006	06/12/2006	25	$128.75	$106.32
05/29/2006	06/05/2006	25	$128.75	$106.32
05/22/2006	05/29/2006	25	$128.75	$106.32
05/15/2006	05/22/2006	25	$128.75	$106.32
05/08/2006	05/15/2006	25	$128.75	$106.32
05/01/2006	05/08/2006	25	$128.75	$106.32
04/24/2006	05/01/2006	25	$128.75	$106.32
04/17/2006	04/24/2006	25	$128.75	$106.32
04/10/2006	04/17/2006	25	$128.75	$106.32
04/03/2006	04/10/2006	25	$128.75	$106.32
03/27/2006	04/03/2006	25	$128.75	$106.32
03/20/2006	03/27/2006	25	$128.75	$106.32
03/13/2006	03/20/2006	25	$128.75	$106.32
03/06/2006	03/13/2006	25	$128.75	$106.32
02/27/2006	03/06/2006	25	$128.75	$106.32

Non-Emergency Transportation (NET) Procedures
(MR 2935)

Georgia Medicaid provides non-emergency transportation (NET) to Medicaid Recipients who need Medicaid services and have no other means of transport. The transportation system is called the Broker System.

All counties in the State are grouped into five (5) regions for NET services.

Each region is covered by a NET Broker. If NET services are needed, the customer must contact the NET Broker serving the county of residence to ask for non-emergency transportation. Do **NOT** contact the NET Broker if there is another means of transportation available to get to the health care provider. Do **NOT** call the NET provider directly.

Contact the Broker to ask for NET services at least three (3) workdays (do not count weekends or holidays) before a routine appointment. For example, if the appointment is scheduled for Friday, call the Broker by the Tuesday before to ask for transportation. Call the Broker as soon as possible if same day service or urgent care is needed and the trip cannot be planned three days in advance.

Broker telephone lines are open Monday - Friday from 7:00 a.m. to 6:00 p.m. to schedule trips.

Family Medicaid

Participant Guide

NEWBORN MEDICAID

Objectives

☐   Participants will be able to identify who may make a request for Newborn Medicaid coverage.

☐   Participants will be able to identify the SOP for processing Newborn Medicaid requests.

☐   Participants will be able to identify the age limit for Newborn Medicaid.

☐   Participants will be able to determine eligibility for Newborn Medicaid.

☐   Participants will be able to apply the eligibility requirements for Newborn Medicaid coverage on SUCCESS.

Outline

I.   Introduction

II.   Application Processing (MR 2050, 2065, 2174 and 2752)

III.   Eligibility Requirements for Newborn Coverage (MR 2174)

IV.   Barbara Woods Walk Through SUCCESS Case

NEWBORN MEDICAID
SUMMARY OF POINTS OF ELIGIBILITY (MR 2174)

Eligibility Requirements: Child born to a mother who is eligible for and receiving Medicaid. Eligibility period is 13 months beginning with the month of birth. The newborn is the only AU member.

Criterion	Summary of the Policy
Standard of Promptness (MR 2065, 2174, 2706)	**Application Process:** Newborn must be approved within 10 calendar days from the date of report. No formal application or interview required. **Reviews:** Not required **Continuing Medicaid Determination:** Must be completed in the last month of Newborn Eligibility.
Request for Coverage (MR 2174)	Coverage can be requested by: ➢ the mother ➢ a Medicaid Participating Provider

NEWBORN MEDICAID CRITERIA			
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
ADDR	**Residency (MR 2225)**	Newborn must continue to live in Georgia.	Accept A/R statement.
STAT	**Living with a Specified Relative (MR 2245)**	Not required.	Accept A/R statement.
DEM1	**Enumeration (MR 2220)**	Not required.	
DEM1	**Age (MR 2255)**	Newborn is eligible for up to 13 months beginning with the month of birth.	Accept A/R statement of birth unless questionable.
DEM1	**Cooperation with Child Support Services (MR 2250)**	Not required; however, the mother must be advised that CSS services are available to her. If the mother is interested, she must be provided with written information on how to contact the local CSS office.	
DEM2	**Citizenship/Alienage/Identity (MR 2215)**	Citizenship/alienage/identity status does not have to be established for a child to receive this COA. US citizenship is assumed.	
DEM2	**Third Party Resources (MR 2230)**	Not required; however, Case Manager must inquire about TPR and submit any information obtained to DCH.	
RES1	**Resources (MR 2301 and 2174)**	Not a requirement.	
ERN1	**Income (MR 2174)**	Not a requirement.	
ERN2	**Budgeting (MR 2174)**	Not a requirement.	
UINC	**Application for Other Benefits (MR 2210)**	Not required.	

Newborn Medicaid
(MR 2174)

Medicaid-eligible Mom gives birth

Baby eligible for Newborn Medicaid for 13 months

Newborn Medicaid Examples

1. Ms. Elaine Joseph was receiving RSM-PgW Medicaid during her pregnancy. Her baby, Bradley, was born on 2/13 and her RSM-PgW continued through 4/4. She received $800 per month in disability during her maternity leave. She now has day care arrangements for Bradley and has returned to work earning $2140 per month.

    a.   Is Bradley eligible to receive Newborn Medicaid?

    b.   If yes, how long will he potentially remain eligible?

2. Ms. Cindy Carter receives RSM-PgW Medicaid. She gives birth on 4/25 to a premature baby, Jack. The baby remains in the hospital for 3 months. Ms. Carter's RSM-PgW Medicaid eligibility ends effective July. The AU is not eligible for LIM.

    a.   Is Jack eligible to receive Newborn Medicaid?

    b.   If yes, how long will he potentially remain eligible?

3. Minor, 16 years old and pregnant, receives RSM-PgW Medicaid. She gives birth on 9/12, and chooses to give the baby up for adoption.

    a.   Is the baby eligible to receive Newborn Medicaid?

    b.   If yes, how long will the baby potentially remain eligible?

Newborn Medicaid Examples (continued)

4.   Ms. Susan Sims receives LIM for herself and her son Seth. Also in the home is her boyfriend Sam Smith, who is NOT Seth's father. Ms. Sims is pregnant with Sam's child. Mr. Smith has monthly wages of $1100. The baby, Joey, is born on 9/17.

   a.   Is Joey eligible to receive Newborn Medicaid?

   b.   Why or why not?

5.   A pregnant woman and her children receive LIM. She gives birth on 6/25.

   d.   Is the baby eligible to receive Newborn Medicaid?

   e.   Is the baby eligible for any other Family Medicaid COA?

ADD A NEWBORN

This is a four-step process:

      Step 1 – Register the Newborn application   **J**

           Step 2 – Complete the interview   **O**

               Step 3 – Process the application   **P**

                  Step 4 – Finalize the application   **Q**

NEWBORN MEDICAID – BARBARA WOODS
WALK THROUGH

Background – Ms. Barbara Woods (32) recently gave birth to a beautiful baby girl. Hospital personnel informed Ms. Woods that as an SSI recipient, her newborn child may be eligible for Medicaid coverage.

Ms. Woods came into the office on 10/5/06 to apply for coverage for her baby. Her daughter, Tanisha, was born on 10/2/06. Tanisha is a non-Hispanic, black female. The hospital has already filed an application for a Social Security number for Tanisha.

Conduct an interview with Ms. Woods to register an F15 Newborn Medicaid application for Tanisha.

The trainer will walk through this process.

STEP ONE - J

AMEN

- Select J to begin the registration process

- Enter the AU ID number

NAME

- Barbara Woods

- Does not reside in public housing

- Does not wish to register to vote

- Resides at 2120 North Hamilton Road, Apt. 6B, Atlanta, GA 30303

- Phone number is 404-862-3921

- Receives mail at same address

- Press PF4 to bypass warning message

KIND

- Enter Y to select AFDC Related Medicaid

- Press ENTER

CIRC

- No data to enter

- Press ENTER

MEMB – BARBARA WOODS

- Born 3/16/74, verified by A/R's statement

- Non-Hispanic, black female

- SSN is 893-01-XXXX, verified by A/R's statement

- Not pregnant

- Press ENTER

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

  F Name BARBARA        MI     L Name WOODS              Suf
  Relationship SE   DOB (MM DD YYYY) 03 16 1974   V CS   Sex F
  SSA/SSN Appl For    SSN1 893 01 XXXX   V CS   Race: B W A N P  Ethnic:  N
  Preg N   Due Date                                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 0013
  0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
```

NAME/SSN CLEARANCE – BARBARA WOODS

- Enter Y in Assign New Client ID

- Press ENTER

```
 HRRS0070             CLIENT REGISTRATION SYSTEM    CICSV2    10/05/2006
                         NAME/SSN CLEARANCE                    09:09:15

 CLIENT ID L NAME            F NAME        MI    DOB    SEX     SSN
 000000001 WOODS             BARBARA            03 16 1974  F    893 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 L
       0000 POSSIBLE MATCHES             TYPE OF MATCH   PRIMARY NAME
 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
 NO MATCHES FOUND
 F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

MEMB – BARBARA WOODS

- Enter Y in the More Members field

- Press ENTER

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

  F Name BARBARA      MI    L Name WOODS           Suf
  Relationship SE   DOB (MM DD YYYY) 03 16 1974   V CS   Sex F
  SSA/SSN Appl For     SSN1 893 01 XXXX   V CS   Race: B W A N P  Ethnic:  N
  Preg  N   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 Y

  Message 0013
```

MEMB – TANISHA WOODS

- Date of birth is 10/02/06; verified by AR's statement

- Non-Hispanic, black female

- SSN applied for at birth

- Press ENTER

```
 REGISTER                      HOUSEHOLD MEMBER - MEMB                MEMB 04

 Client ID              Del

 F Name TANISHA       MI     L Name WOODS            Suf
 Relationship CH   DOB (MM DD YYYY) 10 02 2006    V CS   Sex F
 SSA/SSN Appl For B   SSN1              V       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
```

NAME/SSN CLEARANCE – TANISHA WOODS

- Enter Y in Assign New Client ID

- Press ENTER

```
 HRRS0070               CLIENT REGISTRATION SYSTEM    CICSV2     10/05/2006
                         NAME/SSN CLEARANCE                      09:09:15

 CLIENT ID L NAME              F NAME      MI   DOB     SEX     SSN
 000000001 WOODS               TANISHA        10 02 2006  F    000 00 0000
  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 L
       0016 POSSIBLE MATCHES             TYPE OF MATCH   PRIMARY NAME
 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

  F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

MEMB – TANISHA WOODS

- Press ENTER

INCH

- Do not select F01

- Enter Y in Ind field below F01

- Enter MA in Program field

- Enter F15 in MA COA field

- Application date is 10/02/06

- Press PF4 to bypass the warning message regarding printing an AFA

```
 REGISTER                    INFORMED CHOICE - INCH                    INCH

  HOH Name BARBARA        WOODS                    Client ID XXXXXXXXX
  Indicate/add all programs the head of household wishes to apply for

   Ind        Program            Med COA          AU ID
        MA MED ASST            F01
    Y      MA                      F15



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

                             Appl Date 10 02 06




  Message 0013
  0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                    18-tbud        20-afa
```

REDI

- Press PF4 to bypass warning message regarding scheduling an
  appointment

STEP TWO - O

AMEN

- Select O to begin the interview process

- Press ENTER

ADDR

- Resides in DeKalb County

- Information from Registration is pre-populated

- Press PF21 access the NARR screen for documentation

NARR

- Document the following on the NARR:

  OV - Ms. Woods came into the office to apply for Medicaid coverage for her newborn daughter, Tanisha. Ms. Woods is an SSI recipient and states Tanisha was born on 10/2/06. An F15 case was registered to provide coverage for Tanisha. Ms. Woods is the best source of information regarding the birth of her child.

```
UPDATE                      NARRATIVE – NARR                    NARR
                                                                 01

   10/05/2006 03:55 PM FM Family Medicaid Training 555-555-5555
   OV – Ms. Woods came into the office to apply for Medicaid coverage
   for her newborn daughter, Tanisha.  Ms. Woods is an SSI recipient
   and states Tanisha was born on 10/2/06.  An F15 case was registered
   to provide coverage for Tanisha.  Ms. Woods is the best source of
   information regarding the birth of her child.




                                                                 More
 MESSAGE
   13- bott
```

- Press ENTER to return to ADDR

ADDR

- Press PF4 to bypass warning message

STAT A – F15

- Relationship verified by AR's statement (enter OT)

- Enter N in Mandatory Include field for Barbara

- Enter NM in Financial Responsibility field for Barbara

- Enter Y in Mandatory Include field for Tanisha

- Enter PN in Financial Responsibility field for Tanisha

- Access ADT to enter documentation

```
 INTERVIEW                    ASSISTANCE STATUS - STAT                STAT    A
 Month 11 06                     8991    10 05 06                        01

 AU ID XXXXXXXXX  Prog MA  Prog Type F  Prev ABD Type   Med COA F15   Claim N
    CO 044    LO 049    Load ID 1798    Conversion Date

  AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty----  Appeal
 Stat    Reasons     Date      Date     Date     Date    Type  End Date   Ind
  P                 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
 BARBAR WOO   SE OT   N    NM   P 100506        100206
 TANISH WOO   CH OT   Y    PN   P 100506        100206




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

```
UPDATE                        REMARKS - REMA                        REMA
                                                                      00
  ***************************** MEDICAID STAT *****************************
  10/05/2006 04:10 PM FM Family Medicaid Training 555-555-5555
  LIST OTHER   NAME                   RELAT      AGE      FIN RES {Y/N}
  HH MEMBERS  :BARBARA WOODS_____   :MOTHER___  :_32__   :_Y_____
  NOT  INCL   :_____   :_____   :____   :_____
  IN THE AU   :_____   :_____   :___ _  :_____
  INELIGIBLE/PENALIZED AU MEMBER? Y/N (N) IF YES, EXPLAIN:_____
  :_____
  EXPLAIN STEP PARENT SITUATION:_____
  TRACE RELATIONSHIPS AND DOCUMENT FINANCIAL RESPONSIBILITY:
  :_____
  LIM ELIGIBLE? Y/N (N) IF NO, EXPLAIN:NEWBORN IS ELIGIBLE FOR F15 COVERAGE
  CMD, AS NEEDED:_____
  DUAL ELIG AU MEMBER(S)/COA? EXPLAIN:_NEWBORN AND LIM_____
  3MP COVERAGE RQSTD.? Y/N(N) IF YES, MO. AND DETERMINATION FOR EA.:_____ _
  :_____
  CROSS REF AU#s FOR 3MP AND ONGOING:_____
  EXPLAIN USE OF 500 DENIAL CODE:_____
                                                                    More
  MESSAGE
  0019 UPDATE COMPLETED SUCCESSFULLY

  13-bott
```

DEM1 – BARBARA WOODS

- No data

- Press ENTER

DEM2 – BARBARA WOODS

- No data

- Press ENTER

DEM1 – TANISHA WOODS

- Enter 10/02/06 in SSN Application Date field

- Lives at home

- Does not receive SSI

- Press ENTER

```
 INTERVIEW                  CLIENT DEMOGRAPHIC 1 – DEM1              DEM1 04
 Month 11 06                     8991   10 05 06

 Client Name TANISHA          WOODS               Suf     Client ID XXXXXXXXX

 Alt    SSA/SSN   SSN Appl    SSN1     V   More         DOB      V Sex Race Eth
 Name   Appl For   Date                   SSNs    (MM DD YYYY)
        B       10 02 06                           10 02 2006   CS  F   B   L


 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
```

DEM2 – TANISHA WOODS

- U.S. Citizen; verified by AR's statement

- Health Check referral made on 10/5/06

- Press ENTER through remaining screens

DONE

- Press ENTER to commit to the database

STEP THREE - P

AMEN

- Select P to process the application months

- Press ENTER

APP1

- Enter Y in the Select field for 10/06

- Press ENTER

ADDR

- Fastpath to DONE

- Press PF4 to bypass warning message

DONE

- Commit to the database

APP1

- Press PF13 to return to AMEN

STEP FOUR - Q

AMEN

- Select Q to finalize the application

- Press ENTER

APP2

- Press ENTER

ELIG 10/06 – F15

- If correct, enter Y to confirm the data

- Press ENTER

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

 AU ID XXXXXXXX    Prog MA    Prog Type F    Med COA F15
 Confirm Y

  AU    AU Status   AU Stat    Appl     Begin    Pd Thru  ---Penalty---
 Stat    Reasons     Date      Date      Date     Date    Type  End Date
  A                 100506    100206   100106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date         Date    Date   Date     T  Date
 BARBAR WOO   SE OT   N    NM   A 100506       100206
 TANISH WOO   CH OT   Y    RE   A 100506       100206  100106




 Message
```

CAFI 10/06 – F15

- If correct, enter Y to confirm the data

- Press ENTER

```
 FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI        CAFI    A
 Month 10 06
  AU ID XXXXXXXXX   Prog MA   Prog Type F      Med COA  F15
                                 Net Income Test (cont)
  Resources                       Standard - 30 1/3        .00
    Resource Limit        .00   Dependent Care          .00
    Total Resources       .00   Net Earned Income       .00
  Gross Income Test             Net Unearned Income     .00
    Gross Income Limit    .00   Deemed Income           .00
    Gross Earned Income   .00   Allocated Income        .00
    Net Unearned Income   .00   Net Income              .00
    Deemed Income         .00   Grant Amount            .00
    Allocated Income      .00   Recoupment Amount       .00
  Total Gross Income      .00   Benefit Amount          .00
  Net Income Test               Previous Benefit        .00
    Net Income Limit      .00   Spenddown Amount
    Gross Earned Income   .00   Medical Expense Amt
    Self Employ Work Exp  .00   Net Spenddown Amt
  Bnft Eff Date 100506  Bnft Confirm Y  Reasons         Budgeting Method P
  Notice Type 0003        Waive Timely Ntc Period        Notice Override
   Review Begin Date 10 06   Review End Date 10 07         Strat 2
  Message


    13-note
```

ELIG 11/06 – F15

- If correct, enter Y to confirm the data

- Press ENTER

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

  AU ID XXXXXXXXX    Prog MA    Prog Type F    Med COA F15
  Confirm Y

  AU     AU Status  AU Stat    Appl    Begin    Pd Thru  ---Penalty---
  Stat     Reasons    Date     Date     Date     Date    Type  End Date
  A                   100506  100206   100106
  ---------------------------------------------------------------------------
  First Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
  Name  Name         Incl Resp    Date         Date   Date   Date    T  Date
  BARBAR WOO   SE OT  N    NM   A 100506        100206
  TANISH WOO   CH OT  Y    RE   A 100506        100206 100106




  Message
```

CAFI 11/06 – F15

- If correct, enter Y to confirm the data

- Press ENTER

```
 FINALIZE              CASH/MA FINANCIAL ELIGIBILITY - CAFI            CAFI    A
 Month 11 06
  AU ID 48322xxxx    Prog MA    Prog Type F       Med COA   F15
                                   Net Income Test (cont)
  Resources                        Standard - 30 1/3         .00
    Resource Limit          .00    Dependent Care            .00
    Total Resources         .00    Net Earned Income         .00
  Gross Income Test                Net Unearned Income       .00
    Gross Income Limit      .00    Deemed Income             .00
    Gross Earned Income     .00    Allocated Income          .00
    Net Unearned Income     .00    Net Income                .00
    Deemed Income           .00    Grant Amount              .00
    Allocated Income        .00    Recoupment Amount         .00
  Total Gross Income        .00    Benefit Amount            .00
  Net Income Test                  Previous Benefit          .00
    Net Income Limit        .00    Spenddown Amount
    Gross Earned Income     .00    Medical Expense Amt
    Self Employ Work Exp    .00    Net Spenddown Amt
  Bnft Eff Date 100506  Bnft Confirm Y   Reasons             Budgeting Method P
  Notice Type 0003        Waive Timely Ntc Period            Notice Override
   Review Begin Date 10 06    Review End Date 10 07            Strat 2

 Message
       13-note
```
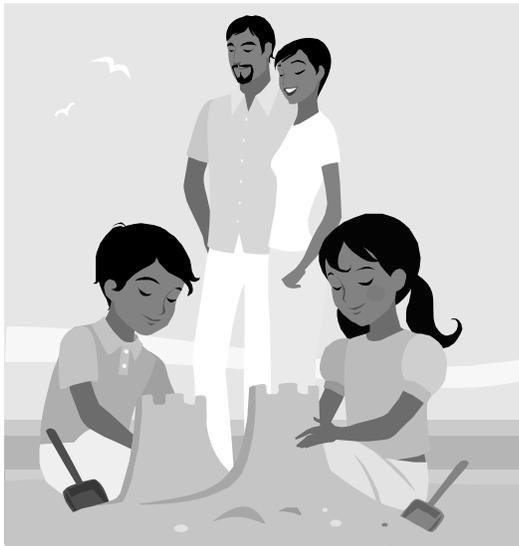
APP2

- Enter Y to finalize the F15 application

- Press ENTER

Outstanding!

Family Medicaid

Participant Guide

LOW INCOME MEDICAID

Objectives

☐   Participants will be able to use information from Form 94 to determine Medicaid eligibility for the appropriate class of assistance.

☐   Participants will be able to apply the eligibility requirement for non-financial criteria for a LIM application.

☐   Participants will be able to apply the appropriate resource limit and verification requirements for a LIM application.

☐   Participants will be able to determine the countable resource value for common resource types for a LIM application.

☐   Participants will be able to apply income limits and verification requirements for a LIM application.

☐   Participants will be able to identify and apply the appropriate budgeting procedures for a LIM application.

☐   Participants will be able to apply the appropriate deductions for a LIM application.

☐   Participants will be able to enter basic information on SUCCESS at Intake for a LIM application.

☐   Participants will be able to complete a LIM Prior Months application on SUCCESS.

☐   Participants will be able to enter appropriate documentation.

Outline

I.   Introduction

II.   Low Income Medicaid (MR 2050, 2052, 2065, 2162 and 2706)

III.   Kelly Landon Walk Through SUCCESS Case

IV.   Non-Financial Requirements (MR 2200, 2610, 2620 and 2657)

V.   Financial Requirements (MR 2301, 2308, 2399, 2400 and 2499)

VI.   Budgeting Requirements (MR 2053, 2650, 2653 and 2663)

VII.   Family Medicaid Deductions (MR 2650, 2653 and 2655)

VIII.   Notification (MR 2050, 2065 and 2701)

IX.   Antonio Klein Independent Study SUCCESS Case

X.   Kelly Landon Prior Months Walk Through SUCCESS Case

XI.   Antonio Klein Prior Months Independent Study SUCCESS Case

XII.   Jane Simmons Capstone SUCCESS Case

LOW INCOME MEDICAID (LIM)
SUMMARY OF POINTS OF ELIGIBILITY (MR 2162)

Eligibility Requirements: An AU eligible for Medicaid based on LIM non-financial and financial criteria can include adult(s). Eligibility period is indefinite as long as the AU meets all eligibility requirements.

Criterion	Summary of the Policy
Processing Standards (MR 2050, 2065, and 2706)	**Registration:** Within 24 hours of receipt by agency. **SOP:** Disposition within 45 calendar days beginning with the date of application. **Exception:** Pregnant women must be approved within 10 calendar days if pregnancy has not yet terminated. **Reviews:** Must be completed by the last work day of the month in which it is due.
Application Forms (MR 2065)	An application for **Medicaid** can be made with any of these forms: ➢ Form 297 (Form 297-A and 297-M also required) ➢ Form 94 ➢ SUCCESS Application for Assistance (AFA) ➢ Form 222 ➢ Form 700 ➢ PeachCare for Kids application ➢ Internet Medicaid application ➢ Low Income Subsidy Application – SSA 1020B ➢ Form DMA632W – Women's Health Medicaid Application ➢ Women's Health Medicaid Review form
Mandatory Forms (MR 2065)	Complete the following mandatory forms when processing a Family Medicaid application: ➢ Eligibility Determination Document (EDD) or other written interview form ➢ Form 216, Declaration of Citizenship ➢ Form 5460, Notice of Privacy Practices ➢ Form DMA-285, Third Party Liability Health Insurance (if TPL/ TPR reported) ➢ Form 138, Cooperation with Child Support Services (if a referral is required)

LOW INCOME MEDICAID CRITERIA			
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
ADDR	**Residency (MR 2225)**	AU must live or intend to live in Georgia. A permanent dwelling or fixed address is not required.	Accept A/R statement.
STAT	**Living with Specified Relative (MR 2245)**	All children in the AU must be related to and living in the home with the person receiving assistance on their behalf. Check Medicaid policy manual, chapter 2245 for list of acceptable relationships.	Accept A/R statement.
DEM1	**Enumeration (MR 2220)**	Each AU member must provide an SSN or proof of application for a number. Good cause may apply for failure to provide.	➢ Accept A/R statement of SSN if the number is known. ➢ Can also accept AU statement for application of SSN in order to process the application, but verification is required in the third month following the month of approval.
DEM1	**Age (MR 2255)**	Children must be under 18.	Accept A/R statement.
DEM1	**Supplemental Security Income (MR 2499)**	Exclude the person who receives SSI from the AU. Also exclude their income and resources.	
DEM2	**Citizenship/ Alienage/Identity (MR 2215)**	AU members must be a U.S. Citizen or qualified alien; see MR 2215 for alien policy. All AU members must declare citizenship/alien status. ➢ If citizen – third party verification of citizenship/identity is required. ➢ If alien - verify status with DHS documents and complete Web1 VIS/CPS procedures. ➢ Obtain a Declaration of Citizenship/Alien Status for each AU member.	

LOW INCOME MEDICAID CRITERIA			
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
DEM2	**Third Party Resources (MR 2230)**	AU members assign rights to Third Party Resources to the Department of Community Health when an application for Medicaid is filed.	➤ Accept A/R statement as to whether anyone in the AU has insurance. ➤ If a TPR exists, Form DMA-285 must be signed and placed in the case record. The top copy must be sent to HMS. ➤ If no TPR exists and application is made with Form 94, 222, 297M, 700 or PCK that include assignment of TPR rights – do not complete DMA-285. ➤ If no TPR exist and neither of the above forms with assignment rights is used, the DMA-285 must be completed/placed in the case record at application and review.
APID	**Child Support Services (MR 2250)**	Recipients must assign their rights to medical support to the state and cooperate with CSS in the location of AP and the collection of medical support. Referrals must be made for all absent parents who are not providing health insurance. Referrals are not required for LIM child-only cases.	
RES1	**Resource Limit (MR 2301, 2308)**	$1000 per AU.	Verify by third party jointly owned/real property, vehicles, when interest paid from a resource totals $10 or more or if total countable value exceeds $750. Accept A/R statement for all other resources unless questionable.

		LOW INCOME MEDICAID CRITERIA	
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
RES2	**Vehicles (MR 2308)**	Exclude any vehicle that is: ➢ used as a home ➢ income producing (over 50% of time) Deduct $4650 from the equity value of one vehicle. Count the equity value of ALL OTHER VEHICLES.	
ERN1	**Earned Income Deductions (MR 2655)**	Must be an employed AU member to receive these deductions ➢ $90 ➢ $30 plus 1/3 for 4 consecutive months; then $30 only for 8 more months ➢ $30 and 1/3 does not have to be given unless it's needed for the AU to be eligible; it can be "saved" until needed ➢ Dependent care not to exceed maximums (see below)	
ERN1	**Earnings of a Dependent Child (MR 2650)**	Exclude the earnings of any dependent child whether or not the child is a student. Exception: Earnings of a minor caretaker are not excluded.	Accept A/R statement of amount earned unless questionable.
ERN2	**Budgeting (MR 2653)**	Prospective Budgeting is used in all cases. Prior months use actual income.	
CARE	**Dependent Care Deduction (MR 2655)**	BG member must be employed to receive this deduction. Allowed the actual amount paid up to the maximums: ➢ $200 per month for each person under 2 ➢ $175 per month for each person 2 or over	Accept A/R statement of amount paid unless questionable.
UINC	**Child Support Deduction (MR 2655)**	Apply $50 deduction to the total amount of child support received by the AU.	
UINC	**Application for Other Benefits (MR 2210)**	A/R must apply for and accept all monetary benefits any AU member is entitled to receive, except TANF and SSI.	Accept A/R statement. Follow up is required in the third month following the month potential eligibility is indicated; third party verification required.

LOW INCOME MEDICAID CRITERIA			
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
UINC	**Income Limits (MR 2650)**	The gross countable income of the AU must be **less than or equal to** the Gross Income Ceiling (GIC) for the AU size. The net income of the AU must be **less than** the Standard of Need (SON) for the AU size.	
UINC	**Income Verification (MR 2051, 2405)**	All income must be verified by third party source. Accept A/R statement for excluded income.	

LOW INCOME MEDICAID APPLICATION – KELLY LANDON WALK THROUGH

Background – Ms. Landon is applying for Low Income Medicaid for herself and her child, Robert. Her application was registered on 10/5/06 and has been assigned to you for completion. Ms. Landon has never received Medicaid before. Though she would rather not receive any public assistance, Robert visited the doctor's office several times in July and August so she needs assistance with the costs. She filed the application in the office on 10/5/06 and is willing to wait for an interview.

Ms. Landon is divorced from Robert's father and provides the sole means of support for her family. She is employed at United Insurance Company and earns $7.40 per hour. She only works 20 hours per week, but expects her hours to increase to full-time soon. She was previously employed at Blue Cross Blue Shield of Georgia but was laid off in December of last year. She received Unemployment Compensation Benefits for a short period of time before locating the job with United Insurance.

Robert is a fourth grade student at Cedartown Elementary and spends every other weekend with his father, Michael Landon. Mr. Landon is employed part-time but is unable to pay any child support at this time. He hasn't paid any child support since June, but assures Ms. Landon that he will resume his payments when he is able to locate a better job.

Ms. Landon states that her family's only resources include cash of $35.00 and a checking account at SunTrust with a balance of $427.00. She purchased a 2003 Ford Focus last month. The car is valued at $6,728.00 according to NADA. She got a good deal on the car and only owes $2,320.00.

- Review the Form 94 and attached verification before entering her eligibility information on SUCCESS.

- O, P and Q her Medicaid applications.

- Carefully review the ELIG and CAFI screens prior to finalizing.

- The trainer will walk through each of these screens and provide additional information.

INTERVIEW

AMEN

- Select O and enter the AU ID number for the F01 case to begin the interview process

- 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 0543
0543 THIS DATA WILL BE WRITTEN TO THE DATABASE

```

ADDR

- Information from Registration is pre-populated

- Enter Residential County Code 044

- Press PF21 to access the NARR screen to enter documentation

```
INTERVIEW                  HOUSEHOLD ADDRESSES - ADDR               ADDR 01
 Month 11 06                         0691   10 05 06

CO 044  LO 049  Load ID 1760  Client ID 901000741  RES CO 044
HOH F Name KELLY          MI      L Name LANDON                    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
         332         PEACHTREE            ST        NE
City ATLANTA             ST GA   Zip 30308 3210   Phone 404 657 8989


 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 2132     2133
2132 CORRECT STREET NUMBER OR EMTER RES CO FIELD
          15-lett                              21-narr  23-alau  24-del
```

NARR

- Document the following on the NARR:

  OV - Ms. Landon is applying for Medicaid for herself and her son Robert. Form 94 was received in the office on 10/5/06. A face-to-face interview was conducted with Ms. Landon on 10/5/06. Ms. Landon is the best source of information regarding her family's circumstances. Ms. Landon is employed part-time at United Insurance and earns $7.40/hr. Her family has no other income. Ms. Landon is requesting prior months coverage for 7/06 and 8/06. HIPAA form signed on 10/5/06 and is in the case record.

```
UPDATE                      NARRATIVE – NARR                    NARR
                                                                 01

  10/05/2006 03:55 PM Family Medicaid Training 555-555-5555
  OV - Ms. Landon is applying for Medicaid for herself and her son Robert.    Form 94 was
  received in the office on 10/5/06.  A face-to-face interview was conducted with Ms.
  Landon on 10/5/06.  Ms. Landon is the best source of information regarding her
  family's circumstances.  Ms. Landon is employed part-time at United Insurance and
  earns $7.40/hr.  Her family has no other income.  Ms. Landon is requesting prior
  months coverage for 7/06 and 8/06.  HIPAA form signed on 10/5/06 and is in the case
  record.




                                                                       More
  MESSAGE

  13-bott
```

Degrees of Relationship for LIM
(MR 2245)

The following relationships are within the specified degree to apply for LIM for a child:

◆ _____

◆ _____

◆ _____

◆ _____

◆ _____

◆ _____

◆ _____

◆ _____

Relationship is established by one of the following:

◆ _____

◆ _____

◆ _____

Tracing Degrees of Relationship
(MR 2245)

Relationship can be established by A/R statement, but the relationship needs to be traced and documented.

For example, "Joan Smith is the great-aunt of Sarah Jones" is not sufficient documentation. Instead, diagram the relationship with the names of the people involved.

```
Joan Smith ———— Sally Smith
                      |
                Pamela Jones
                      |
                 Sara Jones
```
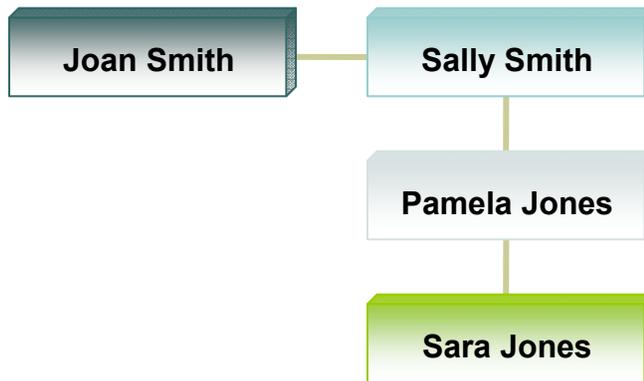
If the client statement is questionable, then request verification of relationship.

If there is no relationship, then a child may still be eligible for Medicaid via RSM where relationship is not a requirement.

Who to Include in the LIM AU
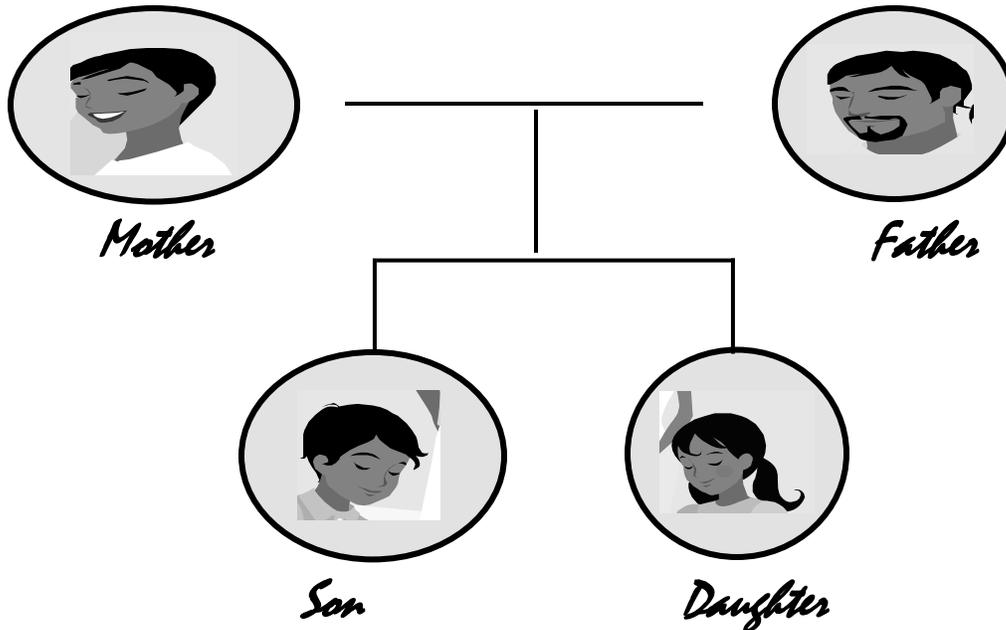
1. Identify individuals living in the home.

2. Exclude the following from the AU:

   - Individual who does not meet the citizenship/alienage requirement
   - Individual who is penalized for failure to meet the enumeration, cooperation with CSS or TPR requirement
   - SSI recipient
   - Individual who does not meet a point of basic eligibility
   - Any child whose inclusion makes another child ineligible

3. Identify and include child(ren) for whom application is being made. Identify and include parents who have not been excluded in Step 2.

4. Include the following individuals at the discretion of the A/R:

   - Children within the specified degree of relationship to the adult making the application
   - One adult living in the home who is within the specified degree of relationship if there is no parent in the home or if the only parent in the home receives SSI.

STAT

- Relationship is verified by AR's statement (use code OT)

- All individuals are mandatory to be included in the AU

- Ms. Landon and Robert are applicants

- Press the Tilde key to access the ADT to enter documentation

```
INTERVIEW                    ASSISTANCE STATUS - STAT                    STAT    A
 Month 11 06                     0691   10 05 06                          01

AU ID 226525415  Prog MA  Prog Type F  Prev ABD Type    Med COA F01   Claim N
   CO 044    LO 049    Load ID 1760    Conversion Date

 AU    AU Status   AU Stat    Appl     Begin    Pd Thru  ---Penalty----  Appeal
Stat    Reasons     Date      Date     Date      Date    Type  End Date   Ind
 P                 100506    100506
-----------------------------------------------------------------------------
First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
Name   Name         Incl Resp   Date          Date    Date   Date    T  Date
KELLY  LAN    SE OT   Y    PN  P 100506        100506
ROBERT LAN    CH OT   Y    PN  P 100506        100506




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

```
UPDATE                       REMARKS - REMA                       REMA
                                                                  00
  ***************************** MEDICAID STAT *****************************
  10/05/2006 04:10 PM Family Medicaid Training 555-555-5555
  LIST OTHER   NAME                  RELAT       AGE     FIN RES {Y/N}
  HH MEMBERS  :_____ :_____ :_____ :_____
  NOT  INCL   :_____ :_____ :_____ :_____
  IN THE AU   :_____ :_____ :_____ :_____
  INELIGIBLE/PENALIZED AU MEMBER? Y/N (N) IF YES, EXPLAIN:_____
  :_____
  EXPLAIN STEP PARENT SITUATION:_____
  TRACE RELATIONSHIPS AND DOCUMENT FINANCIAL RESPONSIBILITY:
  :_____
  LIM ELIGIBLE? Y/N (Y) IF NO, EXPLAIN:_____
  CMD, AS NEEDED:_____
  DUAL ELIG AU MEMBER(S)/COA? EXPLAIN:_____
  3MP COVERAGE RQSTD.? Y/N(Y) IF YES, MO. AND DETERMINATION FOR EA.:_ 7/06
  : and 8/06
  CROSS REF AU#s FOR 3MP AND ONGOING:_____
  EXPLAIN USE OF 500 DENIAL CODE:_____
                                                                  More
MESSAGE
0019 UPDATE COMPLETED SUCCESSFULLY
  13-bott
```

DEM1 – KELLY LANDON

- Divorced

- Lives in the home

- Does not receive SSI

- Press PF9 to access REMA to enter documentation indicating that Form 138 was signed by AR on 10/5/06

```
INTERVIEW                  CLIENT DEMOGRAPHIC 1 - DEM1              DEM1 01
 Month 11 06                        0691   10 05 06

 Client Name KELLY           LANDON               Suf      Client ID 901000741

 Alt    SSA/SSN   SSN Appl     SSN1      V   More         DOB      V Sex Race Eth
 Name   Appl For    Date                    SSNs    (MM DD YYYY)
                              101 01 1760  CS          12 09 1970  CS  F   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       D         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

        15-lett                    16-crs            23-alau
```

Citizenship

A U.S. citizen is an individual who is one of the following:

born in one of the 50 states, District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands (St. Thomas, St. Croix and St. John), Northern Mariana Islands (Saipan, Rota and Tinian), American Samoa, or Swains Island.

a child adopted by a U.S. citizen (Refer to Child Citizenship Act on page 2215-2)

minor child born in another country to a non-U.S. citizen becomes a citizen when the parent resides in the U.S. for the required period of time and becomes a naturalized citizen.

born in another country to a U.S. citizen.

Primary Documents

- Current or expired U.S. passport (not limited passports)
- Certificate of Naturalization (N-550 or N-570)
- Certificate of Citizenship (N-560 or N-561)

Secondary Documents   (also requires verification of identity)

- U.S. public birth record
- U.S. birth certificate or data match with a State Vital Statistics Agency
- Certification of Report of Birth (DS-1350)
- Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)
- Certification of Birth Abroad (FS-545)
- United States Citizen Identification Card (I-197 or I-179)
- American Indian Card (I-872)
- Northern Mariana Identification Card (I-873) or Collective Naturalization for those who lived in the Northern Mariana Islands
- Final Adoption Decree
- Evidence of civil service employment by the U.S. government
- Official military record showing a U.S. place of birth

Third Level Documents   (also requires verification of identity)

- Extract of hospital record on hospital letterhead
- Life or health or other insurance record showing a U.S. place of birth
- Religious record recorded in the U.S. within 3 months of birth
- Early school record showing a U.S. place of birth

Fourth Level Documents   (also requires verification of identity)

- Federal or State census record showing U.S citizenship or U.S. place of birth
- Institutional admission papers from a nursing home, skilled nursing care facility or other institution indicating a U.S. place of birth
- Medical (clinic, doctor, or hospital) record indicating a U.S. place of birth
- Other document that shows a U.S. place of birth
    - a Seneca Indian tribal census record
    - Bureau of Indian Affairs tribal census records of the Navajo Indians
    - a U.S. State Vital Statistics official notification of birth registration
    - a delayed U.S. public birth record that was recorded more than 5 years after the person's birth
    - a statement signed by the physician or midwife who was in attendance at the time of birth
    - Bureau of Indian Affairs Roll of Alaska Natives
- Form 219 Citizenship Affidavit (only used in rare circumstances as a last resort) by two U.S. Citizens of whom one is not related to the A/R and who have personal knowledge of the event(s) establishing the A/R's claim of citizenship. **NOTE:** An affidavit may be used to verify citizenship of anyone or identity of a child, but not both

PRODUCTION REGION

DEM2 for KELLY LANDON

```
INTERVIEW                    CLIENT DEMOGRAPHIC 2 - DEM2                 DEM2 01
Month 11 08                           AUTO   10 05 08

Client Name KELLY         LANDON                        Client ID XXXX00292

 Citz V  Orig Id Stdnt V  Grade V Striker ---Immunization -- Law -Health Chk -
      Cert    Stat     Compl    Stat   Curr GCse Due Dt  Brkr Ref    Date
   C  GM  Y   DL                    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

 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       17-mo< 18-mo>              22-tpl 23-alau
```

INFORMATION
DEM2 is a client-level screen. It is a continuation of the demographic information entered on DEM1.

KEY FIELDS
Citiz: For U.S. citizens, use a code of C. For undocumented aliens who want EMA, use a code   of U.

V: See information on following pages.

Orig Cert: For Medicaid only, use a code of Y if original document provided; use code N if original document not provided. Coding with an N will result in Medicaid being denied or terminated.

Id: (Medicaid only): The identity field is only a requirement for Medicaid cases. The valid values are as follows:

> **DL** (Driver's license)
> **TR** (American Indian or Tribal documents)
> **MI** (Military ID)
> **GI** (Government issued ID)
> **SI** (School Identification)
> **PS** (U.S. Passport issued with limitations)
> **SR** (School Record)
> **HR** (Hospital Record)
> **DC** (Daycare or nursery school record)

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. There has been no change in citizenship or identity policy.

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 Department 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 Department 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.

Citizenship Verification Valid Values (All Programs)	
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. This includes 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.

Citizenship Verification Valid Values (TANF & Food Stamps Only)	
Use these codes only if the citizenship documentation received is not acceptable for the Medicaid program but is acceptable in Food Stamps and TANF. **Use of these valid values will result in denial or termination of Medicaid benefits.**	
SP (Prior SSN)	(SSN issued prior to 6/30/1948)
CR (Court Record)	Court records of parentage, juvenile proceedings, or child support indicating place of birth
PR (Property Record)	Property records verifying U.S. citizenship status
SR (School Record)	Early school records showing the date of admission to the school, the child's date and place of birth, and the name(s) and place(s) of birth of the parents
OG (Other Government records)	Any document that establishes place of birth or U.S. citizenship such as records from SSA, VA, local government agencies, hospitals, clinic's record of birth or parentage Evidence of civil service employment by the U.S. government before 6/1/76 Census record showing the name, U.S. citizenship or a U.S. place of birth, and date of birth or age of the individual

Coding of Citizenship Identity for Newborns		
Code Citizenship as **CS**	Original Document as **Y**	Identity as **AF**

Coding for Failure to Verify Citizenship for Food Stamps and Medicaid	
For FS - Code Citizenship Field as **UA**	SUCCESS will remove A/R from AU and change their financial responsibility to **ND**
For Medicaid - Code Citizenship Field as **UA**	SUCCESS will remove A/R from AU and change their financial responsibility to **UE**

Coding for Failure to Verify Identity for Medicaid	
Code Identity Field as **UA**	SUCCESS will remove A/R from AU and change their financial responsibility to **UE**

Coding for Failure to Provide Original Documents	
Code Original Field as **N**	SUCCESS will remove A/R from AU and change their financial responsibility to **UE**

Coding for Refusal to Verify Citizenship in Medicaid	
Code Citizenship Field as **NV**	SUCCESS will remove A/R from AU and change their financial responsibility to **RV**

If citizenship/identity is not verified for a child in a LIM case, or original documents are not provided as verification, the child should be coded with a financial responsibility of NM and a denial code of 511 once the DEM2 screen is coded, which will remove the child from the AU. Please note that if citizenship/identity is not verified for a child in an RSM or a FM Medically Needy case, the financial responsibility will change to RP instead of UE so the child remains in the budget group.

DEM2 – KELLY LANDON

- U. S. Citizen as verified by her birth certificate

- Identity is verified by her Georgia driver's license

- Agrees to cooperate with Third Party Liability

- Press the Tilde key to access the ADT for documentation

```
INTERVIEW                  CLIENT DEMOGRAPHIC 2 - DEM2              DEM2 01
 Month 11 06                      0691   10 05 06

 Client Name KELLY          LANDON                 Client ID 901000741

 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

 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


 Non-Custodial Parent?     V


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

```
UPDATE                      REMARKS - REMA                         REMA
                                                                    01
   ****************** Health Insurance/Citizenship/Identity ******************
   10/05/2006 12:29 AM Family Medicaid Training 555-555-5555
   Does A/R have health insurance or other TPL {trust,e.g.}?  Y/N (N)
   If yes, date form 285 sent to DMA:_____
   Assignment of TPL rights completed? Y/N ( )
   Signed form DMA 285 in the record, if necessary? Y/N (N)

   Customer was informed about Health Check by
   Face to Face(X) Telephone( ) Mailed Brochure( )

   Citizenship verified by:_BIRTH CERTIFICATE IN CR; ORIGINAL VIEWED BY CM_
   :_____
   Identity verified by: _GA DRIVER'S LICENSE_____
   :_____
   Declaration of citizenship in record dated:_10/5/06_____

   FS only - Citizenship Good cause waiver granted due to:_____
   :_____
                                                                    More
 MESSAGE

 13-bott
```

  *Note: The Citizenship verification code in the production region is GM.

DEM1 – ROBERT LANDON

- Lives in the home

- Does not receive SSI

- Deprived due to the absence of his father

- Press PF9 to access REMA to enter documentation

```
INTERVIEW                    CLIENT DEMOGRAPHIC 1 - DEM1            DEM1 02
 Month 11 06                          0691   10 05 06

 Client Name ROBERT         LANDON              Suf      Client ID 901000742

 Alt    SSA/SSN   SSN Appl     SSN1    V   More        DOB     V Sex Race Eth
 Name   Appl For   Date                   SSNs    (MM DD YYYY)
                            101 02 1760  CS          03 10 1997  CS  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      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       A   CS


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

REMA

A/R states Michael Landon is the father of Robert. They divorced in
March 2006. Mr. Landon spends every other weekend with Robert,
but is unable to pay any child support at this time as he is employed
only part-time. She last saw him last weekend. He is 37 years old,
born in Atlanta. Mr. Landon is a white male, 6'2'', with red hair and
green eyes. He weighs approximately 185 pounds. He lives on
Prairie Lane in Atlanta and can be reached at 404-262-6551. He
does not provide any health insurance for Robert.

DEM2 – ROBERT LANDON

- U. S. Citizen as verified by Birth Certificate

- Full-time student in the fourth grade

- Health Check referral made on 10/5/06

- Press the Tilde key to access the ADT to enter documentation

```
INTERVIEW                 CLIENT DEMOGRAPHIC 2 - DEM2                 DEM2 02
 Month 11 06                      0691   10 05 06

 Client Name ROBERT         LANDON               Client ID 901000742

 Citiz V  Student V  High Grade V Striker ---Immunization -- Law -Health Chk -
        Stat        Completed    Stat   Curr GCse Due Dt  Brkr Ref   Date
   C   BC   FT   CS    03    CS   N                         Y   10 05 06

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


 Non-Custodial Parent?     V


 Message

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

```
UPDATE                      REMARKS - REMA                      REMA
                                                                01
   ****************** Health Insurance/Citizenship/Identity ******************
   10/05/2006 12:29 AM Family Medicaid Training 555-555-5555
   Does A/R have health insurance or other TPL {trust,e.g.}?  Y/N (N)
   If yes, date form 285 sent to DMA:_____
   Assignment of TPL rights completed? Y/N ( )
   Signed form DMA 285 in the record, if necessary? Y/N (N)

   Customer was informed about Health Check by
   Face to Face(X) Telephone( ) Mailed Brochure( )

   Citizenship verified by:_BIRTH CERTIFICATE IN CR; ORIGINAL VIEWED BY CM_
   :_____
   Identity verified by: _DECLARATION OF CITIZENSHIP FORM SIGNED BY AR_____
   :_____
   Declaration of citizenship in record dated:_10/5/06_____

   FS only - Citizenship Good cause waiver granted due to:_____
   :_____
                                                                  More
 MESSAGE
  13-bott
```

*Note: The Citizenship verification code in the production region is GM.

ALAS – ROBERT LANDON

- Attends Cedartown Elementary

```
INTERVIEW                   ALIENS AND STUDENTS - ALAS                 ALAS 02
 Month 11 06                      0691   10 05 06

 Client Name ROBERT        LANDON                    Client ID 901000742
                                        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
   C



 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
   FT     EL    CEDARTOWN ELEMENTARY

 School Attend Cd


 Message 0013     2123
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
              15-lett
```

APID – MICHAEL LANDON

- Michael Landon is not in the home

- He is the legal, natural father of Robert

- Ms. Landon agrees to cooperate with OCSS

```
INTERVIEW                ABSENT PARENT IDENTIFICATION - APID          APID   A
 Month 11 06                                                          01


 HOH Name KELLY        LANDON                Del AP    AP Returned Home N
  AP Name MICHAEL              LANDON                 Suf
     SSN          Seq Num

 Dep First Last Legal Pat  Dep First Last Legal Pat  Dep First Last Legal Pat
     Name Name  Rel  Type      Name Name  Rel  Type      Name Name  Rel  Type
  01 ROBERT LAN  LE    NF




 IV-D  --- Good Cause Claim ---   Referral   130 Form    UCB    Other Income
 Coop  Ind Rsn Stat    Date        Date       Date       Ind      Types
   Y
  Union/Local                                                  More APs
  Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
             15-lett              20-next ap           23-alau  24-del
```

APAD – MICHAEL LANDON

- Lives at 1893 Prairie Lane in Atlanta, GA 30303 as of 9/30/06

- Phone number is 404-262-6551

```
INTERVIEW                ABSENT PARENT ADDRESS - APAD              APAD    A
  Month 11 06                                                              01

 HOH Name KELLY         LANDON                  Client ID 901000741
  AP Name MICHAEL       LANDON                  SSN

 Curr Addr Line 1 1893 PRAIRE LANE      Line 2
 City ATLANTA                    ST GA   Zip 30303        Phone 404 262 6551
 Date at Address 09 30 06

 Prev Addr Line 1                       Line 2
 City                     ST     Zip              Phone
 Date at Address

 AP's Father                                          Delete
 Street                   City                     ST    Zip

 AP's Mother                                          Delete
 Maiden
 Street                   City                     ST    Zip

 Message

              15-lett  20-next ap                      24-del
```

APDE – MICHAEL LANDON

- Divorced

- Married on May 12, 1996 in Atlanta, GA

- Ms. Landon's ex-spouse

- Driver's License issued in Georgia

- License Plate MY4RE issued in Georgia

- Birth date is 3/13/69; 37 years old born in Atlanta, GA

- White; 6 feet 2 inches tall; red hair; green eyes; and 185 lbs.

- No military service; never incarcerated

```
INTERVIEW                 ABSENT PARENT DEMOGRAPHIC - APDE        APDE    A
 Month 11 06                                                         01

 HOH Name KELLY        LANDON                  Client ID 901000741
 AP Name  MICHAEL      LANDON                  SSN

 --------- Marital Information ---------   Rel HOH   Drvr Lic    License Plate
 Stat   Date          City        ST       To AP      ST        ST   Number
  D   05 12 96 ATLANTA             GA        XS        GA        GA   MY4RE

    DOB        Approx   ---- Birth Place ----  Sex  Race  Hgt   Hair   Eye  Wgt
 (MM DD YYYY)  Age         City        ST                 Inches Color Color Lbs
  03 13 1969    37     ATLANTA         GA       M    W    74     R      G    185

 -------------------------- Military Information --------------------------
 Stat   ID Num    Branch   Entry Dt   Exit Dt    Allotment Pay   Allotment Recip


 -------------------------- Incarceration Information ----------------------
  Cd   Release Dt Sentence Lgth  Min Confine          Institution
                  Yr    Mo    Yr    Mo
  Message

            15-lett    20-next ap
```

APEM – MICHAEL LANDON

- Employed as a Craftsman at The General Store since 6/06

- The General Store is located on Walnut Grove Drive in Atlanta, GA 30303; phone number unknown

```
INTERVIEW                ABSENT PARENT EMPLOYMENT - APEM          APEM    A
 Month 11 06                                                             01

 HOH Name KELLY         LANDON                Client ID 901000741
 AP Name  MICHAEL       LANDON                SSN

 Primary Employer    Delete      Occupation CRAFTSMAN
 Name THE GENERAL STORE                    Empl Date (MM YY) 06 06
 Address Line 1 WALNUT GROVE DRIVE          Line 2
 City ATLANTA               ST GA   Zip 30303        Phone

 Secondary Employer   Delete      Occupation
 Name                             Empl Date (MM YY)
 Address Line 1                    Line 2
 City                       ST     Zip           Phone

 Former Employer      Delete      Occupation
 Name                             Empl Date (MM YY)
 Address Line 1                    Line 2
 City                       ST     Zip           Phone

 Message

          15-lett   20-next ap                              24-del
```

APCO – MICHAEL LANDON

- Not court ordered to pay child support

```
INTERVIEW                ABSENT PARENT COURT ORDER - APCO          APCO    A
 Month 11 06                                                             01

 HOH Name KELLY         LANDON                Client ID 901000741
 AP Name MICHAEL        LANDON                SSN

 Order      Support      Support    Freq   Payee          Docket
 Date       Obligation   Arrears           Code           Number




 Paying     Date of     Last Pymnt      Agency Receiving Payment
 Support    Last Pymnt   Amount






 Message

          15-lett   20-next ap
```

FOUR STEPS TO COUNTABLE RESOURCES
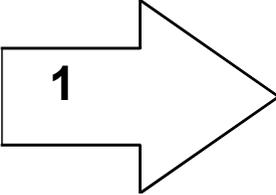
1 Determine the LIM AU and whose resources must be counted.
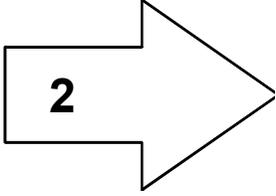
2 Determine availability and the countable resource values for LIM.
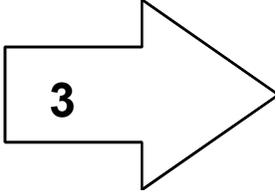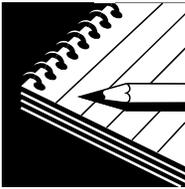
3 Verify resources as appropriate.
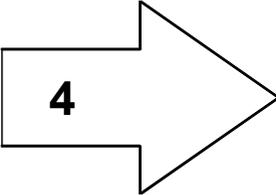
4 Compare the total countable resources to the $1,000 resource limit.

WHOSE RESOURCES TO COUNT IN LIM

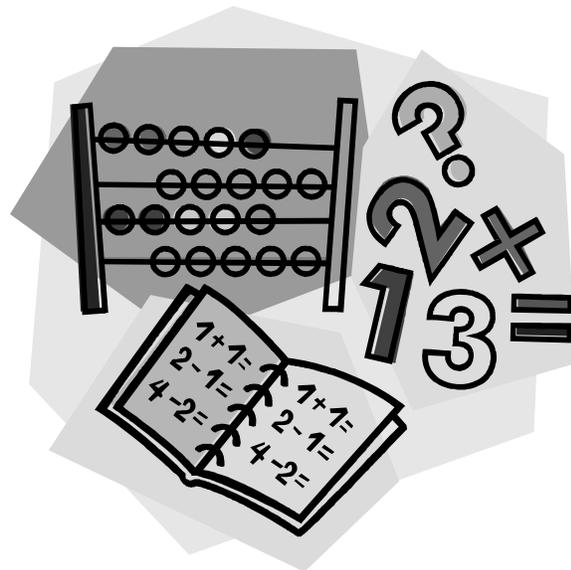|	
COUNT	Caretaker Other eligible adult All eligible children Ineligible aliens Penalized individuals Ineligible parents
DO NOT COUNT	SSI individual Ineligible children Excluded children Non-parent payee only Stepparent Parent(s) of a minor caretaker Spouse of non-parent CT Spouse of a married minor Excluded non-parent relative
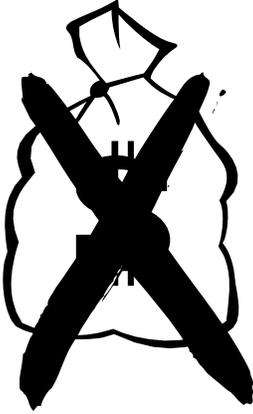
Determining the Value of Resources
(MR 2301-7)

Cash Value (CV)	Amount available if resource could be converted to U.S. funds
Fair Market Value (FMV)	Amount the resource can sell for on the open market in the geographic area involved
Equity Value (EV)	Fair Market Value less legal debts, liens or encumbrances FMV - Amount Owed Equity Value

VERIFICATION OF RESOURCES FOR FAMILY MEDICAID
(MR 2301 & 2308)

Real Property (excluding home place)	Verify at application, review, and when a change occurs.
Jointly Owned Property	Verify at application, review, and when a change occurs.
Amount Owed	Proof of this legal debt, lien or encumbrance must be in writing and signed by the property owner. It must specify the location of the property and the amount of the debt.
Vehicles (non-excluded)	Verify at application, review, and when a change occurs. Verify CMV by one of the following: ➢ a tag receipt or assessed tax value multiplied by 2.5 **or** ➢ the average trade-in value listed in the most current available NADA Official Used Car Guide or at www.nada.com **or** ➢ statement of a dealer If the AU claims the CMV is not representative of the value of the vehicle, the AU must be given the opportunity to provide a value rebuttal from another reliable source, such as a used car/truck dealer, automobile insurance company or classic car appraiser. AU's statement may be accepted as proof of debt or encumbrances on a vehicle, unless questionable. Their statement should identify the vehicle and the current payoff amount.
Interest Earned from ONE Resource Totals $10 or more for a month	Verify account balance at application, review, or when a change occurs.
Total Resources Exceed 75% of the Limit	Verify all resources at application, review, or when a change occurs.
Questionable Information	Verify all resources.

RES1 – KELLY LANDON

- Cash of $35.00

- Checking account at SunTrust with a balance of $427.00

```
INTERVIEW                    RESOURCES 1 - RES1                    RES1 01
 Month 11 06                    0691   10 05 06                      01

 Client Name KELLY          LANDON             Client ID 901000741

 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
    CA      35.00     CS
    CH     427.00     CS                     SUNTRUST



 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
```
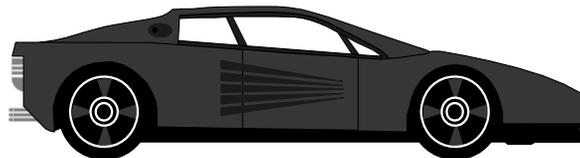
CARS & TRUCKS & MOTORCYCLES & SUCH...
(MR 2308)

Low Income Medicaid

✔ Totally Exclude value if:

   ☛ Used primarily as a home

   ☛ Producing income over 50% of time

✔ Exclude **$4650** off EV of one vehicle per AU, regardless of its use

✔ Count EV of all other vehicles

					FORD 2003-04	43

AV'G Trade - In	BODY TYPE	Model No.	M.S.R.P.	Weight	AV'G Loan	AV'G Retail
2004 FORD-Continued						
ESCORT-FWD						
2875	Hatchback 2D Pony	90	$7402	2242	800	1950
3100	Hatchback 2D LX	91	7806	2249	1000	2225
3175	Hatchback 4D LX	95	8136	2310	1075	2325
3325	Station Wagon 4D LX	98	8737	2313	1200	2700
3525	Hatchback 2D GT	93	9644	2427	1375	2700
TEMPO - FWD						
3225	Sedan 2D GL	31	$9483	2529	1125	2375
3300	Sedan 4D GL	36	9633	2587	1175	2450
3375	Sedan 2D GLS	33	10300	2545	1250	2550
3450	Sedan 4D GLS	36	10448	2603	1325	2625
3500	Sedan 4D LX	37	10605	2628	1350	2675
3575	Sedan 4D 4WD	39	11331	2808	1700	3100
MUSTANG						
5100	Sedan 2D LX	40	$9456	2759	1900	3350
5225	Hatchback 2D LX	41	9962	2824	2025	3500
5550	Convertible 2D LX	44	15141	2960	3200	4950
4725	Sedan 2D LX Sport (V8)	40	12164	3037	2475	4050
6175	Convertible 2D LX Sport (V8)	44	18183	3238	3775	5650
5825	Hatchback 2D GT (V8)	42	13986	3191	3450	5250
7125	Convertible 2D GT (V8)	45	18805	3327	4625	5700
PROBE - FWD						
3950	Hatchback 2D GL	20	$11470	2730	1775	3200
4250	Hatchback 2D LX	21	13008	2970	2025	3525
4550	Hatchback 2D GT Turbo	22	14726	3000	2300	3850
TAURUS - FWD						
3525	Sedan 4D L	50	$13361	3066	1375	2700
3850	Station Wagon 4D L	55	14272	3244	1675	3075
3700	Sedan 4D GL	52	13834	3089	1550	2900
4025	Station Wagon 4D GL	57	14722	3258	1825	3275
4325	Sedan 4D LX	53	16180	3125	2100	3600
4675	Station Wagon 4D LX	58	17771	3285	2425	3975
5325	Sedan 4D SHO	54	21633	3533	3000	4700
LTD CROWN VICTORIA						
4225	Sedan 4D S	72	$16630	3621	2025	3475
4700	Sedan 4D	73	17257	3621	2450	4025
4950	Sedan 4D LX	74	17894	3661	2675	4300
4500	Station Wagon 4D	76	17668	3978	2250	3800
4750	Station Wagon 4D LX	77	18418	3952	2475	4075
4675	Country Squire S/W 4D	78	17921	3972	2425	3975
4900	Country Squire S/W 4D LX ..	79	18671	4050	2625	4250
THUNDERBIRD						
4950	Coupe 2D	60	$14980	3581	2675	4300
5275	Coupe 2D LX	62	17263	3618	2950	4650
6325	Super Coupe 2D	64	20390	3809	3900	5800
2003 FORD						
Veh. Ident.: ()()()()()(Model)()()K()000001 Up.						
FESTIVA - FWD						
2525	Hatchback 2D L	6	$5699	1713	475	1575
2650	Hatchback 2D L Plus	6	6372	1713	600	1700
2725	Hatchback 2D LX	7	7101	1750	675	1800
FOCUS - FWD						
6525	Sedan 2D	90	$6964	2235	475	1550
6728	Sedan 4D LX	91	7349	2242	675	1800

DEDUCT FOR RECONDITIONING
MAY-THRU AUGUST 2003

The letters running down the right margin spell: **D O M E S T I C   C A R S**

TREATMENT OF VEHICLES

Example I

Mr. James Addison (35) applies for Medicaid for himself and three minor daughters. The Case Manager considers LIM eligibility. A/R owns a 1995 Toyota with a CMV of $5300; he also owns a 1987 Ford with a CMV of $300. Nothing is owed on either vehicle. Mr. Addison uses the Ford as transportation to work. His teenage daughter uses the Toyota to drive to high school.

What is the resource limit for this AU in LIM?

What is the total amount to be counted towards the resource limit in LIM?

What must be verified by third party source?

Example II

Ms. Rosemary West (27) applies for Medicaid for herself and her son. The Case Manager considers LIM eligibility. A/R has a 1996 Toyota which she uses to go to work. CMV of the vehicle is $5500 and she owes $200.

What is the resource limit for this AU in LIM?

What is the total amount to be counted towards the resource limit in LIM?

What must be verified by third party source?

Example III

Ms. Kelly Curry (25) applies for Medicaid for herself and her two minor children. The Case Manager considers LIM eligibility. Her only source of income is $300 per month child support. She owns a 2001 Honda, which she uses to look for work, CMV $5000, owes $200. She also has a checking account, balance $85.

What is the resource limit for this AU in LIM?

What is the total amount to be counted towards the resource limit in LIM?

What resources must be verified by third party source?

RES2 – KELLY LANDON

- 2003 Ford Focus LX used for employment valued at $6728 according to NADA

- Owes $2320.00 according to her statement

- Press PF9 to access REMA to document amount owed

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

 Client Name KELLY           LANDON              Client ID 901000741

 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    EM       6728.00  BB 2320.00  CS  03 FORD   FOCUS
                      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
```

RES3 – KELLY LANDON

- No data to enter

TRAN – KELLY LANDON

- No data to enter

RES1, RES2, RES3 and TRAN – ROBERT LANDON

- No liquid or non-liquid resources

WHOSE INCOME TO CONSIDER

When determining financial eligibility for LIM, **consider** the income of the following individuals:

- ☑ All AU members
- ☑ Ineligible parents
- ☑ Penalized individuals
- ☑ Spouses of married minors
- ☑ Spouses of non-parent caretakers
- ☑ Parents of minor caretakers
- ☑ Stepparents

When determining financial eligibility for LIM, **do not** consider the income of the following individuals:

- ✕ Ineligible children
- ✕ SSI Recipients
- ✕ Non-parents not included in the AU

EARNINGS OF A CHILD IN FAMILY MEDICAID
(MR 2499)

IF	THEN
Child is under 18 for LIM-related COAs	**EXCLUDE** earnings
Child is under 19 for RSM	**EXCLUDE** earnings
Child is a minor caretaker	**INCLUDE** earnings
Child is a minor pregnant woman	**INCLUDE** earnings

NOTE: A child is considered eligible for LIM and LIM-related COAs through the month he/she turns 18 and RSM through the month he/she turns 19.

$ VERIFICATION OF INCOME (MR 2405) $

APPLICATION	
All Countable Included Income	Verify
Excluded Income	Accept A/R Statement
Terminated Income	Verify
CHANGES	
New Source	Verify
Income Amount Changes	Verify
Income Terminates	Verify
REVIEW	
Countable Income/Fluctuating	Verify
Countable Income/Stable	Verify
Excluded Income	Accept A/R Statement
New Income	Verify
Terminated Income	Verify

Budgeting

(MR 2653)

```
Conversion Factors:

Weekly       = _____
Bi-weekly    = _____
Semi-Monthly = _____
Monthly      = _____
```

Ms. Rosie Biazon applies for Family Medicaid for herself and her child, Roger on 4/20. She is paid weekly on Wednesdays and provides the following pay stubs as verification, stating that all checks are representative. Case is approved on 5/5.

4/15	$120
4/8	$125
4/1	$123
3/25	$140

a)   What is the gross amount budgeted for April?

b)   What is the gross amount budgeted for May?

c)   What is the gross amount budgeted for June?

Same situation as above except Ms. Biazon states that all checks are representative except 3/25. She had to work a few extra hours until they filled a vacant position. Ms. Biazon states she does not expect to work any extra hours again as the position is now filled.

      a)   What is the gross amount budgeted for April?

      b)   What is the gross amount budgeted for May?

      c)   What is the gross amount budgeted for June?

FAMILY MEDICAID
EARNED INCOME
DEDUCTIONS
(MR 2655)

➢ **$90**

  ✓ EACH WAGE EARNER

➢ **30 & 1/3**

  ✓ EACH WAGE EARNER

➢ DEPENDENT CARE

MAXIMUMS:

  ✓ $200/MONTH PER DEPENDENT UNDER AGE 2
  ✓ $175/MONTH PER DEPENDENT AGE 2 AND OLDER
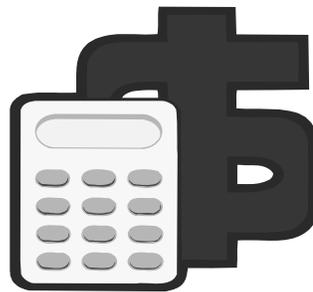
$30 & 1/3 and Low Income Medicaid Facts

✶ $30 & 1/3 may be given for four consecutive months in Low
      Income Medicaid.

✶   In Low Income Medicaid, do not start the $30 & 1/3 count until
      the individual actually needs it in order to qualify. The first month
      (retroactive, current or ongoing) that the $30 & 1/3 is needed for
      the AU to be eligible is the first month in counting the 4
      consecutive months.

✶   Once you begin the count, continue it unless the person has NO
      wages or the $90 deduction zeros wages in one of the months
      (in other words, don't discontinue it because they don't need it).

✶   After the four consecutive $30 & 1/3 months, the recipient will
      receive eight months of the $30 deduction. Once the $30
      deduction begins, it cannot be interrupted. It will continue for 8
      consecutive months regardless of the status of the case.

✶   If a recipient becomes ineligible for Low Income Medicaid due to
      loss of $30 & 1/3 or $30 deduction, complete a Continuing
      Medicaid Determination. TMA is available.

✶   Since Temporary Assistance for Needy Families and Low
      Income Medicaid are separate programs, an individual could be
      in a different count in each one. Track $30 & 1/3 months on
      Form 304 separately for each program.

✶   After receiving $30 & 1/3 for four consecutive months, the AU is
      not eligible to receive $30 & 1/3 in LIM until that AU has been off
      all Medicaid COAs for 12 consecutive months.

ERN1 – KELLY LANDON

- Employed by United Insurance located at 212 Marietta Street, Atlanta, GA 30303

- Phone number is 404-652-3013

- Began employment on 3/15/06; received first pay on 3/31/06

- Enter N in LIM SON Override field

- Press the Tilde key to access the ADT to enter documentation

- $30 & 1/3 months are 10/06 – 9/07

- Clearinghouse screens viewed; no discrepancies noted

```
INTERVIEW                    EARNED INCOME 1 - ERN1             ERN1 01
  Month 11 06                                                        01


 Client Name KELLY         LANDON              Client ID 901000741

 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 UNITED INSURANCE                          AJS Employ
 Line 1 212 MARIETTA STREET        Line 2
 City ATLANTA          ST GA   Zip 30303      Phone 404 652 3013
      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
  EI  03 15 06 03 31 06              N  TANF
                                       LIM N
                                       RSM


 Num of  ABD Stdnt  TANF Student ------JTPA----
 Bordrs  Excl       Ind Cnt   Ind Cnt   Excl
                                                          More Jobs
  Message
          15-lett
```

```
UPDATE                       REMARKS - REMA                      REMA
                                                                   01
   **************************** ERN1 History ****************************
   10/05/2006 12:31 PM Family Medicaid Training 555-555-5555
   EMPLOYER:_UNITED INSURANCE_____
   BEGIN DATE: _____ _____  END DATE:_____   Timely? Y/N ( )
     REASON FOR TERMINATION:_____
     HOW WAS THE TERMINATION VERIFIED:_____
     SHOULD VOLUNTARY QUIT SANCTION BE APPLIED? Y/N ( )
     EXPLAIN:_____

   ACTUAL MONTHS OF 30 & 1/3 FOR TANF:_____
                            MAO:_10/06 – 9/07_____
   :_____
   DOL Hit? Y/N (Y)
   DISCREPANCIES? Y/N (N) Resolution of discrepancies:_____
   :_____
   :_____


                                              More

  MESSAGE
  13-bott
```

How to Get a Good Client Statement

An A/R's statement that she earns $200 per week should not simply be accepted. Budgeting requires that we start with gross income. Most people who work think of what they earn as their net income because that is the income that they actually receive. The kinds of questions that should be asked to arrive at accurate representative income could be, for example:

"How often are you paid?"
"How many hours per week do you work?"
"Do you work these hours every week?"
"How much do you get paid per hour?"
"Do you ever work overtime?"
"When is the next time you expect a raise?"
"Do you expect anything to change in your earnings in the next six months?"

These are the kinds of questions that will help you get accurate and complete information from the A/R. You should request the A/R provide verification from the source of the income. To be complete, this verification should be for the last four consecutive weeks. This verification should then be used to determine representative income.

ERN2 – KELLY LANDON

- Works 20 hours per week

- Paid Weekly on Thursdays

- Earns $7.40 per hour; no verification provided

- Press the Tilde key to access the ADT to enter documentation

- Press PF4 to bypass the warning message

```
INTERVIEW                    EARNED INCOME 2 - ERN2                  ERN2 01
  Month 11 06                       0691  10 05 06                       01

 Client Name KELLY         LANDON                  Client ID 901000741

 Employer Name UNITED INSURANCE

                 Avg Hrs 020   Freq WK   Day Week Pd TH   Extra Pay

 Del

   Amt 1    V     Amt 2    V     Amt 3    V     Amt 4    V      Extra    V
  148.00    ?
 -------------------------   Work Expenses  --------------------------------
           Type  Amount   Freq  V        Type   Amount   Freq  V




                                                          More Jobs
   Message

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

```
UPDATE                      REMARKS – REMA                         REMA
                                                                   01
   ****************************** ERN2 CAL ******************************
   10/05/2006 12:31 PM Family Medicaid Training 555-555-5555
   App(X)  Review( )  New Job ( )  Rate Of Pay ( )  Hrs Chg ( )
   Date of change:_____ Date of Report:_____ Timely( ) Untimely( )
   If new employment, Rate of pay/hours:_____
   EMPLOYER:_UNITED INSURANCE____ _____
    Date Pd     Gross    Tips     Verf    Rep{Y/N}
   1:_____   (       ) (       ):_____ ( ) VERIFICATION OF WAGES
   2:_____   (       ) (       ):_____ ( ) REQUESTED ON 10/5/06;
   3:_____   (       ) (       ):_____ ( ) DUE ON 10/15/06
   4:_____   (       ) (       ):_____ ( )
   5:_____   (       ) (       ):_____ ( )
   6:_____   (       ) (       ):_____ ( )
      Total    :_____ /:_____ = :_____ Rep Pay
   If not Rep, explain:_____
   Freq of pay  WK(X)  BIWK( )  SEMIMTH( )  MONTHLY( )  ACTUAL( )
   Hr Rate:_7.40_____
   CALCULATE Y/N ( )    Cal Monthly Income:_____
                                                         More
   MESSAGE

   13-bott
```

CARE – KELLY LANDON

- Robert attends Boys Clubs of America located at 190 North Avenue, Atlanta, GA

- Telephone number is 404-435-6987

- Pays $30 per week on Mondays; last paid on 10/1/06; verified by her statement

- Press PF9 to access REMA to enter documentation

```
 INTERVIEW                 DEPENDENT CARE EXPENSES - CARE            CARE 01
  Month 11 06                     0691   10 05 06                      01

  Client Name KELLY          LANDON             Client ID 901000741

  Provider BOYS CLUBS OF AMERICA                Phone 404 435 6987
  Address 190 NORTH AVENUE          City ATLANTA          ST GA Zip
                                                     More providers
  Del          Extra Dependent Expense      Day of Week Pd  MO   Rsn  EM

  Depname  Und2 Freq Date Pd   Amt    Date Pd    Amt     Date Pd   Extra   V
  ROBERT    N   WK   10 01 06   30.00
                                                                    CS




                                      More Dependents For This Provider
  Message

            15-lett                                          24-del
```

Example #1

Ms. Wylie has never received Medicaid. She applies in November for herself and three children. A/R verifies that she receives $650/month in wages and pays child care of $100/month. Case is approved in November. The AU is eligible for the $30 and 1/3 deduction but does not need to use it at this time.

The AU ID number is **223456781.**

See Budget on next page.

GEORGIA DEPARTMENT OF HUMAN RESOURCES
TANF BUDGET SHEET

Example #1

Name of Grantee Relative **Ms. Wylie**	Number in AU **4**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change

| AU ID Number
223456781 | Effective Month
November | **C. Standard of Need Test** |

A. Resource Test

Total Nonexempt Resources $ ___0___
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Income Ceiling Test

Gross Income $ ___650___
(Plus deemed, less allocated income)
Gross Income Ceiling $ ___925___
Surplus/Deficit $ _____
Eligible based on ceiling test? ☑ Yes   ☐ No

C. Standard of Need Test

Gross Wages		$ **650.00**
Less Standard Deduction	$90	$ **560.00**
Less Child Care	$**100.00**	$ **460.00**
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$ **460.00**
SON		$ **500**
Surplus/Deficit		$_____

Need?
Eligible for $30 + 1/3?   ☐ Yes   ☑ No

D. Eligibility/Payment Budget   **500**

1. ☑ SON ☐ RSM Limit			
2. Earned Income/**WAGES**	**650.00**		
Total Earned Income	**650.00**	Subtotals	
3. Less $90	**90.00**	**560.00**	
4. Less $30 **Not Needed**		**560.00**	
5. Less 1/3		**560.00**	
6. Less Child Care	**100.00**	**460.00**	
7. Net Earned Income		**460.00**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**460.00**	**460**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **AU is LIM eligible without using $30 & 1/3;**			
15.Benefit Amount **save deduction until it is needed**			

Form 239 (Rev. 03/2009)

Example #2

Mr. and Mrs. Wilson have never received Medicaid. They apply for Medicaid for themselves and their 2 children, Tom (3) and Tim (6) on 8/14. The family has the following resources:

> Checking account - $100
> Savings account - $200
> '99 Ford CMV $4000 (verified by NADA), owes $0

Mr. Wilson states that he received a raise beginning with the check he received on 8/6. He now earns $175 per week. They provide the following verification of Mr. Wilson's wages:

Wages:

> 7/23 - $150
> 7/30 - $150
> 8/6 - $175
> 8/13 - $175

No other income reported. All appropriate verification is provided. Case is processed in August. The AU ID number is **567890125.**

a.   Is the AU eligible for LIM for the application month of August?
       See Example #2A

b.   Is the AU eligible for LIM for the ongoing month (September)?
       See Example #2B

c.   What will be Mr. Wilson's $30 & 1/3 months?

Georgia Department of Human Resources
TANF BUDGET SHEET

Example #2A

Name of Grantee Relative **Mr. & Mrs. Wilson**	Number in AU **4**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change

AU ID Number **567890125**	Effective Month **August**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ __300__
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Income Ceiling Test

Gross Income $ __758.32__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __925__
Surplus/Deficit (circled) $ _____
Eligible based on ceiling test? ☑ Yes   ☐ No

C. Standard of Need Test

Gross Wages		$ __758.32__
Less Standard Deduction	$90	$ __668.32__
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$ __668.32__
SON		$ __500__
Surplus/Deficit		$_____

Need? 500
Eligible for $30 + 1/3?   ☑ Yes   ☐ No

D. Eligibility/Payment Budget

		Subtotals	
1. ☑ SON ☐ RSM Limit			
2. Earned Income/**WAGES**	758.32		$175.00 x 4.3333 $758.32
Total Earned Income	758.32	Subtotals	
3. Less $90	90.00	668.32	
4. Less $30	30.00	638.32	
5. Less 1/3	212.77	425.55	
6. Less Child Care			
7. Net Earned Income		425.55	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		425.55	426
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Eligible for LIM**		
15. Benefit Amount	**$30 & 1/3 months are August, September, October and November**		

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

Example #2B

Name of Grantee Relative **Mr. & Mrs. Wilson**	Number in AU **4**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change
AU ID Number **567890125**	Effective Month **September**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ __**300**__

Resource Limit $ __**1000**__

Eligible Based on Resources? ☑ Yes ☐ No

B. Income Ceiling Test

Gross Income $ __**758.32**__
(Plus deemed, less allocated income)

Gross Income Ceiling $ __**925**__

Surplus/Deficit $ _____

Eligible based on ceiling test? ☑ Yes ☐ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	No

D. Eligibility/Payment Budget — **500**

1. ☑ SON ☐ RSM Limit			
2. Earned Income/**WAGES**	**758.32**		**$175.00** **x 4.3333**
			$758.32
Total Earned Income	**758.32**	**Subtotals**	
3. Less $90	**90.00**	**668.32**	
4. Less $30	**30.00**	**638.32**	
5. Less 1/3	**212.77**	**425.55**	
6. Less Child Care			
7. Net Earned Income		**425.55**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**425.55**	**426**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Eligible for LIM**		
15.Benefit Amount			

Form 239 (Rev. 03/2009)

ERN1, ERN2 AND CARE – ROBERT LANDON

- No earned income or child care costs

UINC – KELLY LANDON

- No unearned income

- Press PF9 to access REMA to enter documentation

- Clearinghouse screens viewed; no discrepancies

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


 Client Name KELLY          LANDON             Client ID 901000741

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
```

UINC – ROBERT LANDON

- No unearned income

RSDI & SSI

RSDI (Retirement, Survivors, Disability Insurance) and **SSI (Supplemental Security Income)** are two very distinct programs, both of which are administered by the Social Security Administration (SSA). It is very important to understand the differences between the two programs.

RSDI stands for RETIREMENT, SURVIVORS, DISABILITY INSURANCE. Each of these words explains what Social Security (RSDI) is.

- ✓ **Retirement** – an individual can receive retirement payments from Social Security starting at age 62. In addition, the spouse and dependent children of this person can also receive benefits through the retired person's account.
- ✓ **Survivors** – the spouse and dependent children of a deceased individual may receive SS benefits through the deceased person's account.
- ✓ **Disability** – an individual can receive disability payments at any age. In addition, the spouse and dependent children of the disabled person can also receive SS benefits through the disabled person's account.

The amount of the RSDI payment is determined by the contributions that were made to their account while employed. If the contributions do not produce a specified minimum amount (which changes annually), then the person can receive either a combination of RSDI and SSI payments, or SSI alone.

SSI stands for SUPPLEMENTAL SECURITY INCOME. A disabled individual of any age (and a person who is 65 or older is defined as disabled) may be eligible for SSI if they are not eligible for RSDI because they have not paid enough contributions into their RSDI account. SSI benefits are paid only to an individual.

When a person applies for RSDI disability, he also applies for SSI. When a person is approved for RSDI disability, he is almost always approved for SSI first because processing for SSI is faster and after two or three months of SSI eligibility he then starts receiving RSDI. This means that almost everyone approved for Disability receives SSI for at least a few months.

A person approved for benefits by the SSA may receive them in one of three ways:

- ✓ receive RSDI only
- ✓ receive SSI only
- ✓ receive a combination of RSDI/SSI

Example #3

Ms. Smith has never received Medicaid. She applies in January for herself and two children. A/R verifies that she receives $250/month in child support. Case is approved in January. This AU does not qualify for the $30 & 1/3 deduction as there is no earned income.

The AU ID number is 635987135.

See Budget on next page.

Georgia Department of Human Resources
TANF BUDGET SHEET

Example #3

Name of Grantee Relative **Ms. Smith**	Number in AU **3**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change
AU ID Number **635987135**	Effective Month **January**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ _____**0**_____
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Income Ceiling Test

Gross Income $ ___**200**___
(Plus deemed, less allocated income)
Gross Income Ceiling $ ___**784**___
Surplus/Deficit $ _____
Eligible based on ceiling test? ☑ Yes   □ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	No

D. Eligibility/Payment Budget   **424**

		Subtotals	
1. ☑ SON □ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)	**200.00**	**200.00**	
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**200.00**	**200**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Eligible for LIM**		
15. Benefit Amount			

Form 239 (Rev. 03/2009)

MISC A

- Enter Y in Auto Reassign Override field

- Enter A in Next Review field

```
INTERVIEW          AU NON-FINANCIAL MISCELLANEOUS - MISC        MISC    A
  Month 11 06                     0691   10 05 06

 HOH Name KELLY          LANDON              Client ID 901000741
 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                      Delay  QMB  RSM
 Compl  Mand  Last  Reasgn   Remain                         Rsn   Ovr  Elig
        Std   Type   Ovr     Amount                                    Ovr
                      Y
 Sched Interview        QC Penalty End Date
 Del     Unit Number 176002    Inquiry Date 10 05 06      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

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

ERRO

- Enter 0014 in Display Error Text for This Code field

- Press ENTER

```
INTERVIEW               CONSOLIDATED ERRORS - ERRO             ERRO
                                                               01

 Display Error Text for This Code

  Code    Screen  AU/Cl    Code    Screen  AU/Cl    Code   Screen  AU/Cl
                  Pntr                     Pntr                    Pntr
  0014    ERN2    01












 Message
```

VERF

- Press PF20 to print the verification checklist

- Press ENTER

```
INTERVIEW                OUTSTANDING VERIFICATIONS - VERF              VERF    A
 Month 11 06                                                                01

 HOH Name KELLY          LANDON                 Client ID 901000741
 AU ID XXXXXXXXX   Prog MA   Med COA F01

 Clnt                                    Clnt
 Pntr   Scrn        Field Name           Pntr   Scrn       Field Name
  01    ERN2    EARNED INCOME AMT




 Message


                                     20-verf   21-nite
```

DONE

- Access the NARR screen to enter documentation regarding
  requested verification and date due

- Press ENTER to commit to the database

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




  AU ID   Prog  Med COA   Elig   - Status -   - Benefit --   Outstanding
                          Req    Code Cfirm    Amt   Cfirm   Verifications
 XXXXXXXXX MA     F01      N      P                              Y






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

Example #4

Ms. Katherine Norwood has never received Medicaid. She applies in October for herself and two children, Lisa and Joey. Ms. Norwood states she has the following resources:

>   Cash - $5.00
>   Checking Account - $78.00
>   '90 Toyota Corolla (CMV $4125.00); owes nothing

She further states that her parents opened a savings account for her son Joey. The savings account has a balance of $50.00.

Ms. Norwood states her family's only income is from her employment with Wal-Mart and the child support that her daughter Lisa receives. Ms. Norwood verifies the child support amount as $100.00/month and provides the following check stubs to verify her wages:

>   10/2 - $139.47
>   9/25 - $123.68
>   9/18 - $131.39
>   9/11 - $120.46

Ms. Norwood states that all of the checks are representative of her usual earnings. Ms. Norwood also verifies that she pays $10.00/week for Joey to attend Little Rascals Day Care Center.

The case is approved in October.

The AU ID number is XXXX00184.

See Budget on next page.

Georgia Department of Human Resources
TANF BUDGET SHEET

Example #4

Name of Grantee Relative **Ms. Norwood**	Number in AU **3**	**Action Taken:** ☑ Trial ☑ Initial ☐ Review ☐ Change
AU ID Number **XXXX00184**	Effective Month **October**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ _____ **133** _____

Resource Limit $1000

Eligible Based on Resources? ☑ Yes   ☐ No

B. Income Ceiling Test

Gross Income $ __ **607.91** __

(Plus deemed, less allocated income)

Gross Income Ceiling $ ____ **784** ____

Surplus/Deficit $ _____

Eligible based on ceiling test? ☑ Yes   ☐ No

C. Standard of Need Test

Gross Wages		$ __**557.91**__
Less Standard Deduction	$90	$ __**467.91**__
Less Child Care	$ __**43.33**__	$ __**424.58**__
Plus Unearned Income	$ __**50.00**__	$ __**474.58**__
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ __**474.58**__
SON		$ __**424**__
Surplus/Deficit		$ _____
Need? Eligible for $30 + 1/3?	☑ Yes	☐ No

D. Eligibility/Payment Budget			**424**
1. ☑ SON ☐ RSM Limit			
2. Earned Income/**Wages**	**557.91**		**$128.75** **x 4.3333** **$557.91**
Total Earned Income	**557.91**	**Subtotals**	**$100 - $50 =** **$50.00**
3. Less $90	**90.00**	**467.91**	
4. Less $30	**30.00**	**437.91**	**$557.91 +** **$50.00 =** **$607.91**
5. Less 1/3	**145.97**	**291.94**	
6. Less Child Care	**43.33**	**248.61**	
7. Net Earned Income			**$10.00 x** **4.3333 =** **$43.33**
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)	**50.00**	**298.61**	
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**298.61**	**299**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Eligible for LIM**		
15. Benefit Amount	**$30 & 1/3 months are October, November, December & January**		

Form 239 (Rev. 03/2009)

PROCESS

AMEN

- Select P to begin processing

- Press ENTER

```
          ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                AMEN

                      Selection P
            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 0543
0543 THIS DATA WILL BE WRITTEN TO THE DATABASE
```

APP1

- Enter Y in Select field for 10/06

- Press ENTER

```
UPDATE                 PROCESS APPL MONTHS - APP1              APP1
                                                               01


 AU ID XXXXXXXXX   Prog MA
 HOH Name KELLY        LANDON              Client ID 901000741


          Sel  Bnft   Status  Med COA     Disposition Status
               Month
           Y   10 06    P       F01     FINAL EDITS NEEDED
               11 06    P       F01     WAITING FINALIZATION











 Message

  13-amen
```

ADDR

- Fastpath to ERN2 01

```
INTERVIEW              HOUSEHOLD ADDRESSES - ADDR           ERN2 01
 Month 11 06                    0691   10 05 06


 CO 044  LO 049  Load ID 1760  Client ID 901000741  RES CO 044
 HOH F Name KELLY          MI     L Name LANDON            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
         332           PEACHTREE            ST          NE
 City ATLANTA           ST GA   Zip 30308 3210   Phone 404 657 8989


 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 2132     2133
 2132 CORRECT STREET NUMBER OR EMTER RES CO FIELD
         15-lett                          21-narr  23-alau  24-del
```

ERN2 – KELLY LANDON

- Enter verification code for Check Stub

- Press PF9 to update the last documentation entered

- Fastpath to DONE

```
CHANGE                        EARNED INCOME 2 - ERN2              ERN2 01
 Month 10 06                        0691  10 05 06                    01

 Client Name KELLY          LANDON              Client ID 901000741

 Employer Name UNITED INSURANCE

                 Avg Hrs 020   Freq WK   Day Week Pd TH   Extra Pay

 Del

   Amt 1   V     Amt 2   V     Amt 3   V     Amt 4   V     Extra    V
    148.00  CH
   ------------------------  Work Expenses  ---------------------------------
          Type  Amount   Freq  V         Type  Amount  Freq  V




                                                         More Jobs
 Message 0013 01
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
            15-lett                       16-evnc        23-alau   24-del
```

```
UPDATE                          REMARKS - REMA                     REMA
                                                                    01
    ******************************* ERN2 CAL ******************************
    10/05/2006 12:31 PM Family Medicaid Training 555-555-5555
    App(X)  Review( )  New Job ( )  Rate Of Pay ( )  Hrs Chg ( )
    Date of change:_____ Date of Report:_____ Timely( ) Untimely( )
    If new employment, Rate of pay/hours:_____
    EMPLOYER:_UNITED INSURANCE  _____
     Date Pd     Gross     Tips      Verf    Rep{Y/N}
    1:10/1/06   (148.00  ) (        ):CHECK STUB_  (Y) VERIFICATION OF WAGES
    2:9/24/06   (148.00  ) (        ):CHECK STUB_  (Y) REQUESTED ON 10/5/06;
    3:9/17/06   (148.00  ) (        ):CHECK STUB_  (Y) DUE ON 10/15/06.
    4:9/10/06   (148.00  ) (        ):CHECK STUB_  (Y) VERIFICATION RECEIVED
    5:_____   (        ) (        ):_____  ( ) ON 10/5/06. CHECK STUBS
    6:_____   (        ) (        ):_____  ( ) IN CR.
       Total     :_592.00_ /:__4_____ = :_148.00_____ Rep Pay
    If not Rep, explain:_____
    Freq of pay   WK(X)  BIWK( )  SEMIMTH( ) MONTHLY( ) ACTUAL( )
    Hr Rate:_7.40_____
    CALCULATE Y/N (Y)    Cal Monthly Income:_641.32_____
                                                            More
    MESSAGE

    13-bott
```

DONE

- Access NARR to update documentation regarding receipt of verification

- Press ENTER to commit

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



   AU ID   Prog  Med COA    Elig   - Status -   - Benefit --   Outstanding
                            Req    Code Cfirm    Amt   Cfirm   Verifications
  XXXXXXXXX MA      F01      N       P









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

APP1

- Enter Y in Select field for 11/06

- Press ENTER

```
UPDATE                  PROCESS APPL MONTHS - APP1              APP1
                                                                 01

 AU ID XXXXXXXXX    Prog MA
 HOH Name KELLY          LANDON                 Client ID 901000741


           Sel  Bnft    Status   Med COA    Disposition Status
                Month
                10 06     P        F01      WAITING FINALIZATION
            Y   11 06     P        F01      WAITING FINALIZATION






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

ADDR

- Fastpath to ERN2 01

```
INTERVIEW                 HOUSEHOLD ADDRESSES - ADDR              ERN2 01
 Month 11 06                      0691   10 05 06


CO 044  LO 049  Load ID XXXX  Client ID 901000741  RES CO 044
HOH F Name KELLY        MI     L Name LANDON                 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
        332          PEACHTREE             ST          NE
City ATLANTA             ST GA   Zip 30308 3210   Phone 404 657 8989

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 2132     2133
2132 CORRECT STREET NUMBER OR EMTER RES CO FIELD
              15-lett                            21-narr  23-alau  24-del
```

ERN2 – KELLY LANDON

- Enter verification code for Check Stub

- Fastpath to DONE

```
CHANGE                    EARNED INCOME 2 - ERN2              DONE
 Month 10 06                     0691   10 05 06                  01

Client Name KELLY         LANDON            Client ID 901000741

Employer Name UNITED INSURANCE

            Avg Hrs 020   Freq WK   Day Week Pd TH   Extra Pay

Del

  Amt 1   V    Amt 2   V    Amt 3   V    Amt 4   V     Extra   V
  148.00  CH
 ------------------------  Work Expenses  -------------------------------
      Type  Amount  Freq V      Type  Amount   Freq V




                                              More Jobs
 Message 0013 01
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
              15-lett                     16-evnc      23-alau   24-del
```

DONE

- Press ENTER to commit

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



   AU ID    Prog  Med COA    Elig    - Status -   - Benefit --   Outstanding
                             Req     Code Cfirm   Amt   Cfirm  Verifications
  XXXXXXXXX MA      F01       N        P













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

APP1

- Press PF13 to return to AMEN

```
UPDATE                  PROCESS APPL MONTHS - APP1                    APP1
                                                                      01

 AU ID XXXXXXXXX    Prog MA
 HOH Name KELLY          LANDON               Client ID 901000741


          Sel  Bnft   Status   Med COA     Disposition Status
               Month
               10 06    P        F01       WAITING FINALIZATION
               11 06    P        F01       WAITING FINALIZATION










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

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative **Kelly Landon**	Number in AU **2**	Action Taken: □ Trial ☑ Initial □ Review □ Change
AU ID Number **XXXXXXXX**	Effective Month **October**	**C. Standard of Need Test**

A. Resource Test	**C. Standard of Need Test**

A. Resource Test		C. Standard of Need Test		
Total Nonexempt Resources $ __462.00__		Gross Wages		$ __641.32__
Resource Limit $1000		Less Standard Deduction	$90	$ __551.32__
Eligible Based on Resources? ☑ Yes □ No		Less Child Care	$ **129.99**	$ **421.33**
		Plus Unearned Income	$_____	$_____
B. Income Ceiling Test		Plus Deemed Income	$_____	$_____
Gross Income $ __641.32__		Less Allocation	$_____	$_____
(Plus deemed, less allocated income)		Total		$ __421.33__
Gross Income Ceiling $ **659**		SON		$ __356__
Surplus/Deficit $ _____		Surplus/Deficit		$_____
Eligible based on ceiling test? ☑ Yes □ No		**Need?** Eligible for $30 + 1/3? ☑ Yes □ No		

D. Eligibility/Payment Budget			356
1. ☑ SON □ RSM Limit			
2. Earned Income/**Wages**	**641.32**		**$148.00** **x 4.3333** **$641.32**
			$30.00 x 4.3333 = $129.99
Total Earned Income	**641.32**	**Subtotals**	
3. Less $90	**90.00**	**551.32**	
4. Less $30	**30.00**	**521.32**	
5. Less 1/3	**173.77**	**347.55**	
6. Less Child Care	**129.99**	**217.56**	
7. Net Earned Income		**217.56**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**217.56**	**218**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Eligible for LIM**		
15. Benefit Amount	**$30 & 1/3 months are October, November, December & January**		

Form 239 (Rev. 03/2009)

FINALIZE

AMEN

- Select Q to finalize

- 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




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

APP2

- Press ENTER

```
UPDATE                   FINALIZE APPLICATION - APP2           APP2
                                                              01

 AU ID XXXXXXXXX    New MA ID
 HOH Name KELLY          LANDON                 Client ID 901000741

 Finalize
      Sel  Bnft   Status   Prog   Med COA      Disposition Status
           Month
       Y   10 06    P       MA     F01     WAITING FINALIZATION
           11 06    P       MA     F01     WAITING FINALIZATION









 Message
```

ELIG 10/06

- If correct, enter Y to confirm

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

 AU ID XXXXXXXXX    Prog MA    Prog Type F    Med COA F01
 Confirm  Y

  AU     AU Status   AU Stat    Appl     Begin    Pd Thru  ---Penalty---
 Stat    Reasons     Date       Date     Date     Date     Type  End Date
  A                  100506     100506   100106
 ----------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date         Date    Date   Date    T Date
 KELLY  LAN   SE OT  Y    RE   A 100506        100506  100106
 ROBERT LAN   CH OT  Y    RE   A 100506        100506  100106




  Message
```

CAFI 10/06

- If correct, enter Y to confirm

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
  Month 10 06
 AU ID XXXXXXXXX    Prog MA   Prog Type F      Med COA  F01
                              Net Income Test (cont)
 Resources                    Standard - 30 1/3     293.77
   Resource Limit     1000.00 Dependent Care        129.99
   Total Resources     462.00 Net Earned Income     217.56
 Gross Income Test            Net Unearned Income       .00
   Gross Income Limit  658.60 Deemed Income             .00
   Gross Earned Income 641.32 Allocated Income          .00
   Net Unearned Income    .00 Net Income            218.00
   Deemed Income          .00 Grant Amount              .00
   Allocated Income       .00 Recoupment Amount         .00
 Total Gross Income    641.32 Benefit Amount            .00
 Net Income Test              Previous Benefit          .00
   Net Income Limit    356.00 Spenddown Amount
   Gross Earned Income 641.32 Medical Expense Amt
   Self Employ Work Exp   .00 Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y   Reasons            Budgeting Method P
 Notice Type 0003          Waive Timely Ntc Period         Notice Override
  Review Begin Date 10 06   Review End Date 04 07           Strat 1
 Message

  13-note
```

ELIG 11/06

- If correct, enter Y to confirm

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

 AU ID XXXXXXXXX     Prog MA     Prog Type F    Med COA F01
 Confirm Y

  AU    AU Status   AU Stat     Appl     Begin    Pd Thru  ---Penalty---
 Stat    Reasons     Date       Date      Date     Date    Type  End Date
  A                 100506     100506    100106
 --------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date        Date   Date   Date    T  Date
 KELLY  LAN   SE OT   Y    RE   A 100506        100506 100106
 ROBERT LAN   CH OT   Y    RE   A 100506        100506 100106




 Message
```

CAFI 11/06

- If correct, enter Y to confirm

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
  Month 11 06
 AU ID XXXXXXXXX    Prog MA   Prog Type F      Med COA  F01
                               Net Income Test (cont)
 Resources                     Standard - 30 1/3      293.77
   Resource Limit      1000.00 Dependent Care         129.99
   Total Resources      462.00 Net Earned Income      217.56
 Gross Income Test             Net Unearned Income       .00
   Gross Income Limit   658.60 Deemed Income             .00
   Gross Earned Income  641.32 Allocated Income          .00
   Net Unearned Income     .00 Net Income             218.00
   Deemed Income           .00 Grant Amount              .00
   Allocated Income        .00 Recoupment Amount         .00
 Total Gross Income     641.32 Benefit Amount            .00
 Net Income Test               Previous Benefit          .00
   Net Income Limit     356.00 Spenddown Amount
   Gross Earned Income  641.32 Medical Expense Amt
   Self Employ Work Exp    .00 Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y   Reasons          Budgeting Method P
 Notice Type 0003      Waive Timely Ntc Period           Notice Override
  Review Begin Date 10 06   Review End Date 04 07          Strat 1
 Message

  13-note
```

APP2

- Enter Y to finalize

```
UPDATE                  FINALIZE APPLICATION - APP2              APP2
                                                                 01

 AU ID XXXXXXXXX   New MA ID
 HOH Name KELLY          LANDON                Client ID 901000741

 Finalize y
       Sel  Bnft    Status   Prog   Med COA       Disposition Status
            Month
            10 06    A       MA     F01        FINALIZED BY WORKER
            11 06    A       MA     F01        FINALIZED BY WORKER






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

Congratulations you have completed a LIM application!

LOW INCOME MEDICAID APPLICATION – ANTONIO KLEIN INDEPENDENT STUDY

Background – Antonio Klein is married to Tisha Klein and they have two children, Karmen and Charles. He has applied for LIM via Form 94. He stopped by the office on 10/2/06 to drop off his Medicaid application at the front desk and clerical support staff made copies of the driver's licenses for Mr. and Mrs. Klein.

The application was received in the county office on 10/2/06, registered on 10/2/06, and assigned to your caseload today for completion.

You contact Mr. Klein by telephone to clarify the information provided on his application.

- Review the Form 94 prior to beginning the eligibility determination.

- Complete the interview, process the application months, and finalize the case using the data that follows.

- Request assistance from the trainer if needed.

INTERVIEW

AMEN

- Select O to begin the interview process

- Press ENTER

ADDR

- Information from Registration is pre-populated

- Residential County Code is 044

- Access NARR to enter documentation

STAT

- Relationship is verified by AR's statement

- All persons are mandatory to be included in the case

- All persons are applicants

- Access ADT to enter documentation

DEM1 – ANTONIO KLEIN

- Married

- Lives at home

- Does not receive SSI

DEM2 – ANTONIO KLEIN

- U.S. Citizen; verified by Vital Records data

- Agrees to cooperate with TPL requirements; no Third Party Resources

- Access ADT to enter documentation

- Identity verified by GA Driver's License

- Declaration of Citizenship form dated 10/2/06 in case record

DEM1 – TISHA KLEIN

- Married

- Lives at home

- Does not receive SSI

- Due date of pregnancy is 5/12/07; verified by doctor's statement

- Expecting one child; verified by doctor's statement

- Access REMA to enter free-form documentation

DEM2 – TISHA KLEIN

- U.S. Citizen; verified by Vital Records

- Agrees to cooperate with TPL requirements; no Third Party Resources

- Access ADT to enter documentation

- Identity is verified by GA Driver's License

DEM1 – KARMEN KLEIN

- Lives at home

- Does not receive SSI

- Deprived due to financial need for Medicaid only

DEM2 – KARMEN KLEIN

- U.S. Citizen; verified by Vital Records

- Full-time kindergarten student

- Health Check referral made on 10/5/06

- Access ADT to enter documentation

- Identity verified by Declaration of Citizenship form

ALAS – KARMEN KLEIN

- Attends Eastside Elementary

DEM1 – CHARLES KLEIN

- Lives at home

- Does not receive SSI

- Deprived due to financial need for Medicaid only

DEM2 – CHARLES KLEIN

- U.S. Citizen; verified by Vital Records

- Health Check referral made on 10/5/06

- Access ADT to enter documentation

- Identity verified by Declaration of Citizenship form

RES1 – ANTONIO KLEIN

- Cash of $55.00; verified by AR's statement

- Checking Account with a balance of $194.00; verified by AR's statement

- Savings Account with a balance of $256.00; verified by AR's statement

- Both accounts are held at Wachovia

RES2 – ANTONIO KLEIN

- Owns a 2001 Honda Accord used for employment

- Vehicle is valued at $2600; verified by NADA

- Nothing is owed on the vehicle

RES3 – ANTONIO KLEIN

- No data to enter

TRAN

- No data to enter

RES1, RES2, RES3 and TRAN – TISHA, KARMEN AND CHARLES

- No liquid or non-liquid resources

ERN1 – ANTONIO KLEIN

- Employed by Home Depot located at 233 Home Depot Lane, Forsyth, GA 31209

- Phone number is 478-555-1254

- Began on 11/1/05; received first pay on 11/19/05

- Enter N in LIM SON Override field

- Access ADT to enter documentation

- $30 + 1/3 months are 10/06 – 9/07

- Clearinghouse screens viewed; no discrepancies noted

ERN2 – ANTONIO KLEIN

- Works an average of 25 hours per week

- Paid weekly on Thursdays

- Enter representative amount; verified by check stubs attached to application

- Access ADT to enter documentation

CARE – ANTONIO KLEIN

- Does not incur a childcare expense

- Wife takes care of the children

- Access REMA to enter documentation

ERN1 – TISHA KLEIN

- Not currently employed

- Access ADT to enter documentation

- Clearinghouse screens viewed; no discrepancies noted

ERN2 – TISHA KLEIN

- No data to enter

CARE – TISHA KLEIN

- No data to enter

ERN1, ERN2 and CARE – KARMEN AND CHARLES KLEIN

- No data to enter

UINC – ANTONIO

- Access REMA to enter documentation

- Clearinghouse screens viewed; no discrepancies noted

UINC – TISHA

- Potentially eligible for UCB

- Referred on 10/5/06

- Clearinghouse screens viewed; no discrepancies noted

UINC – KARMEN AND CHARLES

- No unearned income

MISC A

- Override Auto Reassign

- Next Review is an alternate

DONE

- Press ENTER to commit to the database

PROCESS

AMEN

- Select P

APP1

- Select 10/06

ADDR

- Fastpath to DONE

DONE

- Press ENTER to commit to the database

APP1

- Press PF13 to return back to AMEN

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative	Number in AU	Action Taken: □ Trial □ Initial
		□ Review □ Change

AU ID Number	Effective Month	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? □ Yes   □ No

B. Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on ceiling test? □ Yes   □ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget

1. □ SON □ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

FINALIZE

AMEN

- Select Q

APP2

- Press ENTER

ELIG 10/06

- If correct, enter Y to confirm

CAFI 10/06

- If correct, enter Y to confirm

ELIG 11/06

- If correct, enter Y to confirm

CAFI 11/06

- If correct, enter Y to confirm

APP2

- Enter Y to finalize the case

Congratulations you have completed another LIM application!

PRIOR MONTHS – KELLY LANDON
WALK THROUGH

Background – Ms. Landon indicated on her Medicaid application that her son incurred medical expenses prior to her application for Medicaid coverage. Review the Form 94 to determine for which Prior Months coverage is requested and available.

When asked about her resources, Ms. Landon indicated that she had a balance of $657.00 in her checking account for July and $232.00 in August. She states she had cash of $32.00 in July and $48.00 in August. She further states that she did not purchase her car until September.

Ms. Landon paid $30 each week on Mondays for Robert to attend the Boys Clubs of America's after-school program.

Her wages from United Insurance was the family's only income for July and August.

STEP ONE - 5

AMEN

- Select 5 to copy information to prior month(s)

- Enter Ms. Landon's AU ID #

```
              ASSISTANCE UNIT/CLIENT SUBMENU - AMEN              AMEN

                          Selection 5
                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 0019
0019 UPDATE COMPLETED SUCCESSFULLY
```

PMCO

- Enter Y in Apply field next to appropriate month(s)

- Press ENTER

```
UPDATE                   PRIOR MEDICAID COPY - PMCO            PMCO
                         5991   10 05 06

 HOH Name KELLY       LANDON              Client ID XXXXXXXXX
                      AU ID XXXXXXXXX   Appl Date 10 05 06


           Apply       Benefit       AU        Med
                        Month       Stat       COA

             Y         07 06
             Y         08 06
                       09 06



Message 0963
 0963 PLEASE SELECT RETRO MONTH(S) FOR DATA COPY
```

STEP TWO - R

AMEN

- Select R to update information

- Enter 07/06 in Benefit Month field

- Press ENTER

```
         ASSISTANCE UNIT/CLIENT SUBMENU - AMEN              AMEN

                    Selection R
            AU ID XXXXXXXXX          Client ID
         Screen ID                   As Of Date
Benefit Month (MM YY) 07 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

- Access NARR to document

- Prior month coverage is available for 7/06 and 8/06

- Fastpath to RES1 for Kelly Landon

RES1 – KELLY LANDON

- Update resources data

- Access REMA to enter documentation

RES2 – KELLY LANDON

- Delete the vehicle from the database

- Enter Y in the Del field

- Access REMA to enter documentation

- Fastpath to ERN1 for Ms. Landon

- Press PF24 to confirm deletion

ERN1 – KELLY LANDON

- Press PF9 to update documentation regarding $30 & 1/3

ERN2 – KELLY LANDON

- Change frequency code to Actual

- Enter actual income earned in 7/06

- Press Tilde to access ADT to enter documentation

```
CHANGE                    EARNED INCOME 2 - ERN2                  ERN2 01
Month 07 06                                                            01

Client Name KELLY    LANDON               Client ID XXXXXXXXX

Employer Name UNITED  INSURANCE

                Avg Hrs 20    Freq AC   Day Week Pd TH    Extra Pay

Del

   Amt 1    V    Amt 2    V    Amt 3    V    Amt 4    V    Extra    V
  148.00   CH   148.00   CH   148.00   CH    96.20   CH    96.20   CH
   -------------------------  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
```

CARE

- Update expenses to reflect actual circumstances

- Access REMA to enter documentation

- Fastpath to DONE

```
INTERVIEW                 DEPENDENT CARE EXPENSES – CARE              CARE 01
 Month 11 06                      0691   10 05 06                        01

 Client Name KELLY       LANDON                  Client ID 901000741

 Provider BOYS CLUBS OF AMERICA                  Phone 404 435 6987
 Address 190 NORTH AVENUE        City ATLANTA            ST GA Zip
                                                    More providers
 Del          Extra Dependent Expense      Day of Week Pd  MO   Rsn  EM

 Depname  Und2 Freq Date Pd   Amt     Date Pd    Amt     Date Pd   Extra   V
 ROBERT    N   AC   10 01 06   120.00
                                                                    CS




                                         More Dependents For This Provider
 Message

             15-lett                                              24-del
```

DONE

- Press ENTER to commit to the database

AMEN

- Select R to update information

- Enter 08/06 in Benefit Month field

- Press ENTER

```
        ASSISTANCE UNIT/CLIENT SUBMENU - AMEN              AMEN

                    Selection R
           AU ID XXXXXXXXX          Client ID
        Screen ID                   As Of Date
Benefit Month (MM YY) 08 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

- Fastpath to RES1 for Kelly Landon

RES1 – KELLY LANDON

- Update resources to reflect actual circumstances

RES2 – KELLY LANDON

- Delete the vehicle from the database

- Enter Y in the Del field

- Fastpath to ERN2 for Ms. Landon

- Press PF24 to confirm deletion

ERN2 – KELLY LANDON

- Change frequency code to Actual

- Enter actual income earned in 8/06

- Press Tilde to access ADT to enter documentation

```
CHANGE                    EARNED INCOME 2 - ERN2                ERN2 01
Month 08 06                                                          01

Client Name KELLY     LANDON               Client ID XXXXXXXXX

Employer Name UNITED INSURANCE

                 Avg Hrs 20    Freq AC   Day Week Pd TH   Extra Pay

Del

   Amt 1    V     Amt 2    V     Amt 3    V     Amt 4    V      Extra    V
  148.00   CH    148.00   CH    148.00   CH    148.00   CH
   -------------------------  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
```

CARE

- Update expenses to reflect actual circumstances

- Access REMA to enter documentation

- Fastpath to DONE

```
INTERVIEW                 DEPENDENT CARE EXPENSES - CARE              CARE 01
 Month 11 06                      0691   10 05 06                        01

 Client Name KELLY          LANDON                Client ID 901000741

 Provider BOYS CLUBS OF AMERICA                Phone 404 435 6987
 Address 190 NORTH AVENUE         City ATLANTA           ST GA Zip
                                                   More providers
 Del          Extra Dependent Expense     Day of Week Pd  MO    Rsn   EM

 Depname  Und2 Freq Date Pd   Amt    Date Pd    Amt     Date Pd   Extra   V
 ROBERT    N   AC   10 01 06   150.00
                                                                    CS




                                  More Dependents For This Provider
 Message
              15-lett                                       24-del
```

DONE

- Commit to database

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative	Number in AU	Action Taken: ☐ Trial ☐ Initial
		☐ Review ☐ Change

AU ID Number	Effective Month	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? ☐ Yes   ☐ No

B. Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on ceiling test? ☐ Yes   ☐ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget

		Subtotals	
1. ☐ SON ☐ RSM Limit			
2. Earned Income			
Total Earned Income			
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15.Benefit Amount			

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative	Number in AU	Action Taken: ☐ Trial ☐ Initial
		☐ Review ☐ Change

AU ID Number	Effective Month	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? ☐ Yes   ☐ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

B. Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on ceiling test? ☐ Yes   ☐ No

D. Eligibility/Payment Budget

1. ☐ SON ☐ RSM Limit		
2. Earned Income		
Total Earned Income		**Subtotals**
3. Less $90		
4. Less $30		
5. Less 1/3		
6. Less Child Care		
7. Net Earned Income		
8. Plus Unearned Income		
9. Plus Child Support (Less $50 – Medicaid only)		
10. Plus Deemed Income		
11. Less Allocation		
12. Total Countable Income		
13. Surplus/Deficit (SON less line 12)		
14. Family Maximum		
15. Benefit Amount		

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STEP THREE - 6

AMEN

- Select 6 to finalize

- Press ENTER

```
           ASSISTANCE UNIT/CLIENT SUBMENU - AMEN                AMEN

                        Selection 6
             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 0019
0019 UPDATE COMPLETED SUCCESSFULLY
```

FPME

- Press ENTER

```
 UPDATE              FINALIZE PRIOR MEDICAID - FPME             FPME


  HOH Name KELLY      LANDON              Client ID XXXXXXXXX
  AU ID   XXXXXXXXX

  Finalize

  Bnft      Status     Med    Spenddown   Disposition Status
  Month                COA     Amount

  07 06       P       F01                 WAITING FINALIZATION
  08 06       P       FO1                 WAITING FINALIZATION
  09 06




  Message
```

ELIG 07/06

- If correct, enter Y to confirm

```
 FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG       ELIG   A
 Month 07 06                                                       01

  AU ID XXXXXXXXX    Prog MA    Prog Type F    Med COA F01
  Confirm Y

   AU    AU Status  AU Stat   Appl     Begin    Pd Thru  ---Penalty---
  Stat    Reasons    Date     Date     Date      Date    Type  End Date
   A                 100506   100506   070106   07312006
  ------------------------------------------------------------------------
  First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
  Name   Name         Incl Resp    Date          Date   Date   Date   T  Date
  KELLY  LAN   SE OT   Y    RE   A 100506        100506 070106 07312006
  ROBERT LAN   CH OT   Y    RE   A 100506        100506 070106 07312006





  Message
```

CAFI 07/06

- If correct, enter Y to confirm

```
 FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI   A
  Month 07 06
 AU ID XXXXXXXXX    Prog MA    Prog Type F      Med COA  F01
                                Net Income Test (cont)
 Resources                      Standard - 30 1/3     292.13
   Resource Limit      1000.00  Dependent Care        120.00
   Total Resources      689.00  Net Earned Income     224.27
 Gross Income Test              Net Unearned Income      .00
   Gross Income Limit   658.60  Deemed Income            .00
   Gross Earned Income  636.40  Allocated Income         .00
   Net Unearned Income     .00  Net Income            224.00
   Deemed Income           .00  Grant Amount             .00
   Allocated Income        .00  Recoupment Amount        .00
 Total Gross Income     636.40  Benefit Amount           .00
 Net Income Test                Previous Benefit         .00
   Net Income Limit     356.00  Spenddown Amount
   Gross Earned Income  636.40  Medical Expense Amt
   Self Employ Work Exp    .00  Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y   Reasons        Budgeting Method P
 Notice Type 0003         Waive Timely Ntc Period       Notice Override
  Review Begin Date 10 06    Review End Date 04 07        Strat 1
 Message
  13-note
```

ELIG 08/06

- If correct, enter Y to confirm

```
FINALIZE            NON-FINANCIAL ELIGIBILITY RESULTS - ELIG         ELIG    A
Month 08 06                                                          01

 AU ID XXXXXXXXX    Prog MA    Prog Type F    Med COA F01
 Confirm Y

  AU     AU Status   AU Stat    Appl    Begin    Pd Thru   ---Penalty---
 Stat     Reasons     Date      Date     Date     Date    Type  End Date
  A                  100506    100506   080106   08312006
 ----------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date         Date   Date   Date   T  Date
 KELLY  LAN   SE OT   Y    RE   A 100506       100506 080106 08312006
 ROBERT LAN   CH OT   Y    RE   A 100506       100506 080106 08312006




 Message
```

CAFI 08/06

- If correct, enter Y to confirm

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI         CAFI    A
 Month 08 06
 AU ID XXXXXXXXX    Prog MA   Prog Type F       Med COA  F01
                            Net Income Test (cont)
 Resources                  Standard - 30 1/3      277.33
   Resource Limit     1000.00  Dependent Care       150.00
   Total Resources     280.00  Net Earned Income    164.67
 Gross Income Test             Net Unearned Income     .00
   Gross Income Limit  658.60  Deemed Income           .00
   Gross Earned Income 592.00  Allocated Income        .00
   Net Unearned Income    .00  Net Income           165.00
   Deemed Income          .00  Grant Amount            .00
   Allocated Income       .00  Recoupment Amount       .00
 Total Gross Income    592.00  Benefit Amount          .00
 Net Income Test               Previous Benefit        .00
   Net Income Limit    356.00  Spenddown Amount
   Gross Earned Income 592.00  Medical Expense Amt
   Self Employ Work Exp   .00  Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y  Reasons          Budgeting Method P
 Notice Type 0004        Waive Timely Ntc Period        Notice Override
  Review Begin Date 10 06   Review End Date 04 07        Strat 1
 Message
  13-note
```

FPME

- Enter Y to finalize

```
UPDATE                 FINALIZE PRIOR MEDICAID - FPME                    FPME


 HOH Name KELLY     LANDON                 Client ID XXXXXXXXX
 AU ID   XXXXXXXXX

 Finalize Y

 Bnft      Status      Med      Spenddown     Disposition Status
 Month                 COA       Amount

 07 06       P         F01                    FINALIZED BY WORKER
 08 06       P         FO1                    FINALIZED BY WORKER




 Message
```

PRIOR MONTHS – ANTONIO KLEIN
INDEPENDENT STUDY

Background – Mr. Klein indicated on his Medicaid application that his family incurred medical expenses prior to his application for Medicaid coverage. Review the Form 94 to determine for which Prior Months coverage is requested and available.

Mr. Klein states during your telephone conversation that his family had no resources during this time because he didn't open his accounts or purchase his car until 10/06. The family's only income was from his job at Home Depot. Mr. Klein attached his check stubs to the application.

CapStone Exercise

JANE SIMMONS

Ms. Simmons would like to apply for Medicaid for herself and her two children, Tina and Richard. She is in the office on 10/5/06 to file her application.

Clerical support staff made copies of her family's birth certificates and her driver's license. Ms. Simmons completed Form 94, including the Declaration of Citizenship form.

Ms. Simmons has provided a statement from her employer regarding her wages and a statement from her child's father regarding his child support payments.

After registering her application, you conduct an office interview with her to review the information provided on her application.

Ms. Simmons and her children, Tina and Richard, live alone.

Tina's father is Kenneth Baker. Mr. Baker passed away a few months from a chronic illness. Ms. Simmons has applied for RSDI benefits for Tina.

Richard's father is Lawrence Johnson. Mr. Johnson pays child support for Richard on the first of each month in the amount of $100. Ms. Simmons has provided a written statement from Mr. Johnson dated 9/30/06 verifying this information.

Ms. Simmons agrees to cooperate with all points of eligibility. Additionally, Ms. Simmons has requested Medicaid coverage for the prior month of September as she has an unpaid medical bill dated 9/12/06.

When asked about her employment situation, Ms. Simmons states that she is employed by Brooks Self Storage. She works less than 20 hours per week and earns $108.75 each pay period.

YOUR ASSIGNMENT

Use the information provided to register her application; conduct the interview, process and finalize her initial application; and process her request for prior month's coverage.

ADDRESS

Non-public housing, Bibb County
578 Charter Boulevard
Macon, GA 31210-4858
(478) 458-1187

DEMOGRAPHICS

Jane Simmons
SSN 325-01-XXXX
DOB 6/2/82
Non-Latino; Black
Does not wish to register to vote
Never married
Lives at home
Does not receive SSI
U.S. Citizen; verified by birth certificate
Identity verified by GA Driver's License
Agrees to cooperate with TPL
Has no other health insurance

Tina Simmons
SSN 325-02-XXXX
DOB 3/19/00
Non-Latino; Black
Lives at home
Does not receive SSI
Father is Kenneth Baker, deceased
U.S. Citizen; verified by birth certificate
Identity verified by Declaration of Citizenship form
1st grade student at Oakdale Elementary

Richard Simmons
SSN 325-03-XXXX
DOB 10/25/04
Non-Latino; Black
Lives at home
Does not receive SSI
Father is Lawrence Johnson
U.S. Citizen; verified by birth certificate
Identity verified by Declaration of Citizenship form

ABSENT PARENTS

Lawrence Johnson
Acknowledged, natural father of Richard
Lives at 123 Thomas Drive, Macon, GA 31808
Phone number is 478-291-6700
Never married to Ms. Simmons
DOB 5/15/80; 26 years old
Born in Macon, GA
Black; black hair and brown eyes
6 feet 2 inches tall
Weighs approximately 200 pounds
Employed as a painter since January 1995
Works for Wallace Management on Barnett Street, Macon, GA
Not court ordered to pay child support

Kenneth Baker, deceased
Putative, natural father of Tina
Address unknown
Never married to Ms. Simmons
DOB is unknown; 32 years old
Born in Macon, GA
Black; black hair and brown eyes
6 feet tall
Weighs approximately 180 pounds
Employer unknown
Not court ordered to pay child support

RESOURCES

Ms. Simmons reports cash of $10.00 and a checking account at
Washington Mutual with balance of $25.00. She further states that this
balance was $72.00 in September. She had $20.00 in cash in September.
Ms. Simmons owns a 2000 Toyota Corolla used for employment. The car
is valued at $4125 according to NADA. Ms. Simmons purchased this car in
January 2005 and owes nothing.

INCOME

Jane Simmons
Employed by Brooks Self Storage at 367 Lakeside Dr., Macon, GA 30211
Phone number is 478-466-3211
Began on 9/1/05; first check received on 9/8/05
Works 15 hours per week; paid on Mondays
Earns $7.25/hour; check stubs provided

Pay End Date	Pay Received Date	Amount	Verification
9/5/06	9/7/06	108.75	CH
9/12/06	9/14/06	108.75	CH
9/19/06	9/21/06	108.75	CH
9/26/06	9/28/06	108.75	CH

Richard Simmons
Receives child support of $100/month
Paid directly by Lawrence Johnson
Received on the first of each month
Statement dated 9/30/06 provided

CHILDCARE

Little Rascals, 145 Harper Street, Macon, GA, provides childcare for Richard. The phone number is 478-475-8202. Ms. Simmons pays $10.00 per week on Wednesdays. She last paid this expense on 9/30/06.

Ms. Annie Neal, an elderly neighbor, takes care of Tina after school at no charge. Ms. Neal lives at 562 Charter Boulevard; phone number is 478-623-5689.

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative	Number in AU	Action Taken: □ Trial □ Initial
		□ Review □ Change

AU ID Number	Effective Month	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? □ Yes   □ No

B. Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on ceiling test? □ Yes   □ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget

1. □ SON □ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative	Number in AU	Action Taken: □ Trial □ Initial □ Review □ Change
AU ID Number	Effective Month	**C. Standard of Need Test**

A. Resource Test Total Nonexempt Resources $ _____ Resource Limit $1000 Eligible Based on Resources? □ Yes □ No	

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes □ No	

B. Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on ceiling test? □ Yes   □ No

D. Eligibility/Payment Budget

1. □ SON □ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15.Benefit Amount			

Form 239 (Rev. 03/2009)

Family Medicaid

Participant Guide

CASE MANAGEMENT

Objectives

☐   Participants will be able to identify the types of changes AUs are required to report, the verification requirements, and the Case Manager's time frame for taking action on reported changes.

☐   Participants will be able to identify the correct type of notification the AU will receive.

☐   Participants will be able to identify the effective month a person is added to an AU/BG.

☐   Participants will be able to identify the effective month a person is deleted from an AU.

☐   Participants will be able to identify forms verifying proof of Medicaid coverage.

☐   Participants will be able to issue a temporary Medicaid card via the SUCCESS system.

Outline

I.   Introduction

II.   Reporting of Changes (MR 2712)

III. Verification Requirements

IV.   Adequate and Timely Notice in Medicaid (MR 2701)

V.   Effective Month of Changes (MR 2712-1, 2650 and 2653)

VI.   Changes in AU/BG Composition (MR 2714)

VII. Kelly Landon Walk Through SUCCESS Case

VIII. Katherine Norwood Walk Through SUCCESS Case

IX.   Changes in Income/Deductions (MR 2701 and 2715)

X.   Proof of Medicaid Coverage

XI.   Susan Nelson Walk Through SUCCESS Case

Changes

AU HAS _____ DAYS FROM OCCURRENCE TO REPORT.

CASE MANAGER HAS _____ DAYS TO VERIFY AND ACT ON THE REPORTED CHANGE.

REQUIRED VERIFICATION – NON-FINANCIAL	
TYPE OF CHANGE	**FAMILY MEDICAID REQUIREMENT**
Residence	AU statement accepted unless questionable.
Birth of a baby	AU statement accepted unless questionable.
Decrease in AU/BG size	AU statement accepted unless questionable.
Increase in AU/BG size	AU statement accepted unless questionable. New AU members must provide verification of his/her alien status if not a U.S. citizen. New BG members are NOT required to verify alien status.
Pregnancy	Verification from physician required.
Pregnancy due date	AU statement, unless questionable.

REQUIRED VERIFICATION – FINANCIAL	
TYPE OF CHANGE	**FAMILY MEDICAID REQUIREMENT**
Income - new source or change in amount	Income must be verified. AU statement accepted unless questionable for PgW and Newborn COAs.
Resources (vehicle, real property, life insurance, etc.) – acquisition, sale of, etc.	AU statement accepted unless questionable. Resources must be verified if the total of all liquid and non liquid resources exceeds 75% of the total resource limit.
Dependent care costs	AU statement, unless questionable.

FAILURE TO PROVIDE VERIFICATION	
IF THE AU FAILS TO PROVIDE REQUESTED VERIFICATION OF:	**THEN**
Income (new source or change in amount) **or** Resources (acquisition, sale, etc.) **or** AU/BG size (questionable increase or decrease) **or** Residence (questionable change of)	Terminate Medicaid effective the month following the expiration of timely notice.
Dependent Care expense (questionable)	Remove the original dependent care expense deduction and do not allow the new expense.

Effective Month of Changes

Always ask yourself, "Will the change cause a potential loss of Medicaid coverage?"

Timely Notice

If AU reports:	Then change is effective:
New or increased income	Month after Timely Notice expires
Terminated or decreased deductions	Month after Timely Notice expires

Adequate Notice

If AU reports:	Then change is effective:
Terminated or decreased income	Month after change occurred and was reported
New or increased deductions	Month after change occurred and was reported

ADD AN AU MEMBER

This is a four-step process:

Step 1 – Add the AU member to the existing case   **K**

    Step 2 – Conduct the interview   **O**

        Step 3 – Process the application   **P**

           Step 4 – Finalize the application   **Q**

ADD AN AU MEMBER – KELLY LANDON
WALK THROUGH

Background – Ms. Landon was recently approved for Medicaid for herself and her son, Robert. Ms. Landon phones on 10/5/06 to report that her 15 year old niece, Sheila Morrison, has moved into her home and she would like to add her to her Medicaid case. Sheila moved in on 10/5/06.

Ms. Landon's sister, Marie, is Sheila's mother and she is currently unable to provide for her. Ms. Landon suspects that Marie has a drug addiction problem. Ms. Landon does not know Sheila's father's name.

Sheila Morrison is a U.S. citizen and has no source of income.

Conduct a telephone interview with Ms. Landon to add Sheila to the case.

The trainer will walk through this process.

STEP ONE - K

AMEN

- Select K to begin the Add A Person process

- Enter the AU ID #

NAME

- Information is pre-populated

- Press ENTER

MEMB – SHEILA MORRISON

- Date of birth is 10/02/91; verified by AR's statement

- Non-ethnic, white female

- SSN is 101-03-XXXX

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

F Name SHEILA      MI     L Name MORRISON            Suf
Relationship NN   DOB (MM DD YYYY) 10 02 1991   V CS   Sex F
SSA/SSN Appl For    SSN1 101 03 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 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                        18-tbud                 24-del
```

NAME/SSN Clearance – SHEILA MORRISON

- Enter Y in Assign New Client ID

- Press ENTER

```
HRRS0070                CLIENT REGISTRATION SYSTEM    CICSV2    10/05/2006
                        NAME/SSN CLEARANCE                      09:09:15

 CLIENT ID L NAME            F NAME      MI   DOB     SEX     SSN
 000000001 MORRISON          SHEILA          10 02 1991   F    101 03 0000
 RACE (Y/N)?: BLACK OR AFRICAN AMERICAN N      WHITE  Y      ASIAN  N
 NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER N   AMERICAN INDIAN/ALASKAN NATIVE  N
 ETHNICITY (L/N)?: HISPANIC/LATINO N
      0016 POSSIBLE MATCHES             TYPE OF MATCH  PRIMARY NAME
 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

 F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

MEMB – SHEILA MORRISON

- Press ENTER

INCH

- Select the F01 case

- Application date is 10/05/06

- Press PF4 to bypass warning message regarding printing an AFA

```
ADDPERSON               INFORMED CHOICE - INCH              INCH


 HOH Name KELLY       LANDON                 Client ID XXXXXXXXX
 Indicate/add all programs the head of household wishes to apply for

   Ind        Program           Med COA          AU ID
    Y      MA MED ASST            F01          XXXXXXXXX




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

                         Appl Date 10 05 06

 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                      18-tbud         20-afa
```

REDI

- Press PF4 to bypass warning message regarding scheduling an appointment

STEP TWO - O

AMEN

- Select O

ADDR

- Access NARR to enter documentation

STAT A

- Relationship verified by AR's statement

- Enter Y in Mandatory Include field for Sheila

- Enter PN in Financial Responsibility field for Sheila

- Access ADT 2 to enter documentation

```
INTERVIEW                    ASSISTANCE STATUS - STAT              STAT    A
Month 11 06                        8991   10 05 06                    01

 AU ID XXXXXXXXX  Prog MA  Prog Type F  Prev ABD Type    Med COA F01   Claim N
    CO 044     LO 049    Load ID 1798    Conversion Date

  AU     AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty----   Appeal
 Stat     Reasons     Date      Date     Date     Date    Type End Date     Ind
  A                  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
 KELLY  LAN   SE OT   Y    RE   A 100506        100206
 ROBER  LAN   CH OT   Y    RE   A 100506        100206
 SHEIL  MOR   NN OT   Y    PN   P 100506        100506




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

DEM1 – SHEILA MORRISON

- Lives at home

- Does not receive SSI

- Deprived due to the absence of both parents

- Mother's name is Marie Morrison; whereabouts unknown

- Father's name is unknown

```
 INTERVIEW                    CLIENT DEMOGRAPHIC 1 - DEM1              DEM1 04
 Month 11 06                      8991   10 05 06


 Client Name SHEILA        MORRISON                Suf      Client ID XXXXXXXXX

 Alt    SSA/SSN   SSN Appl    SSN1    V   More        DOB      V Sex Race Eth
 Name   Appl For   Date                  SSNs    (MM DD YYYY)
                          101 01 XXXX CS            10 02 1991   CS   F   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      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        B    CS


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

DEM2 – SHEILA MORRISON

- U.S. Citizen; verified by vital records

- Full-time student

- Completed 9th grade

- Health Check referral made on 10/5/06

- Fastpath to DONE

ALAS – SHEILA MORRISON

- Attends Lakeside High School

ERRO

- Address any unresolved errors

ELIG

- Confirm the data

CAFI

- Confirm the data

DONE

- Commit to the database

STEP THREE - P

AMEN

- Select P

APP1

- Select 10/06

ADDR

- Fastpath to DONE

DONE

- Commit to the database

APP1

- Return to AMEN

STEP FOUR - Q

AMEN

- Select Q

APP2

- Press ENTER

ELIG 10/06

- If correct, confirm the data

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

 AU ID XXXXXXXXX    Prog MA    Prog Type F   Med COA F01
 Confirm  Y

  AU     AU Status   AU Stat    Appl    Begin    Pd Thru   ---Penalty---
 Stat     Reasons      Date      Date    Date     Date    Type  End Date
  A                   100506    100506  100106
 ----------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date          Date    Date   Date    T  Date
 KELLY  LAN   SE OT   Y    RE   A 100506       100506  100106
 ROBERT LAN   CH OT   Y    RE   A 100506       100506  100106
 SHEILA MOR   NN OT   Y    RE   A 100506       100506  100106




 Message
```

CAFI 10/06

- If correct, confirm the data

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
  Month 10 06
 AU ID XXXXXXXXX    Prog MA    Prog Type F      Med COA  F01
                             Net Income Test (cont)
 Resources                       Standard - 30 1/3      293.77
   Resource Limit        1000.00  Dependent Care         129.99
   Total Resources        462.00  Net Earned Income      217.56
 Gross Income Test               Net Unearned Income       .00
   Gross Income Limit     784.40  Deemed Income            .00
   Gross Earned Income    641.32  Allocated Income         .00
   Net Unearned Income      .00   Net Income             218.00
   Deemed Income            .00   Grant Amount             .00
   Allocated Income         .00   Recoupment Amount        .00
 Total Gross Income       641.32  Benefit Amount           .00
 Net Income Test                 Previous Benefit         .00
   Net Income Limit       424.00  Spenddown Amount
   Gross Earned Income    641.32  Medical Expense Amt
   Self Employ Work Exp     .00   Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y   Reasons          Budgeting Method P
 Notice Type 0003         Waive Timely Ntc Period         Notice Override
  Review Begin Date 10 06    Review End Date 04 07          Strat 1
 Message

 13-note
```

ELIG 11/06

- If correct, confirm the data

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

 AU ID XXXXXXXXX    Prog MA     Prog Type F    Med COA F01
 Confirm Y

  AU    AU Status  AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons    Date      Date     Date      Date    Type  End Date
  A                100506    100506   100106
 --------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name        Incl Resp     Date        Date    Date   Date    T  Date
 KELLY  LAN   SE OT   Y    RE  A 100506       100506  100106
 ROBERT LAN   CH OT   Y    RE  A 100506       100506  100106
 SHEILA MOR   NN OT   Y    RE  A 100506       100506  100106




 Message
```

CAFI 11/06

- If correct, confirm the data

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
  Month 11 06
 AU ID XXXXXXXXX   Prog MA   Prog Type F      Med COA  F01
                                Net Income Test (cont)
 Resources                         Standard - 30 1/3      293.77
   Resource Limit        1000.00   Dependent Care         129.99
   Total Resources        462.00   Net Earned Income      217.56
 Gross Income Test                 Net Unearned Income       .00
   Gross Income Limit     784.40   Deemed Income             .00
   Gross Earned Income    641.32   Allocated Income          .00
   Net Unearned Income       .00   Net Income             218.00
   Deemed Income             .00   Grant Amount              .00
   Allocated Income          .00   Recoupment Amount         .00
 Total Gross Income       641.32   Benefit Amount            .00
 Net Income Test                   Previous Benefit          .00
   Net Income Limit       424.00   Spenddown Amount
   Gross Earned Income    641.32   Medical Expense Amt
   Self Employ Work Exp      .00   Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y   Reasons          Budgeting Method P
 Notice Type 0003          Waive Timely Ntc Period        Notice Override
  Review Begin Date 10 06   Review End Date 04 07          Strat 1
 Message

  13-note
```

APP2

- Finalize the application

DELETE AN AU MEMBER – KATHERINE NORWOOD
WALK THROUGH

BACKGROUND
Ms. Katherine Norwood receives Medicaid for herself and her two children, Lisa and Joey. Ms. Norwood phones on 10/5/06 to report that her daughter has moved in with her grandmother, Leila Norwood.

Ms. Leila Norwood resides in Virginia and Lisa is expected to live with her indefinitely. Lisa moved out on 10/5/06.

Ms. Norwood is still employed by Wal-Mart.

YOUR ASSIGNMENT
Remove Lisa from the AU.

AMEN

- Select R

- Enter the AU ID #

ADDR

- Access NARR to document the reported change

- Press ENTER

STAT A

- Enter valid value to indicate that Lisa is no longer in the home

- Access ADT to enter documentation regarding change in AU

- Fastpath to DEM1 for Lisa

DEM1 – LISA

- Enter appropriate valid value to indicate that Lisa is no longer in the home

- Fastpath to DONE

ERRO

- Address any unresolved errors

ELIG A – F01

- Confirm the data

```
CHANGE                  NON-FINANCIAL ELIGIBILITY RESULTS - ELIG        ELIG    A
Month 11 06                        2001    10 16 96                        01

AU ID XXXX00184    Prog MA    Prog Type F    Med COA F01
Confirm Y

  AU     AU Status   AU Stat    Appl     Begin     Pd Thru   ---Penalty---
  Stat     Reasons     Date     Date      Date       Date    Type  End Date
   A                  100206   100206   100106

First  Last  Rel V  Mand Finl  --Stat—Rsn   Appl     Begin  Pd Thru  Penalty
Name   Name         Incl Resp    Date       Date     Date   Date   T  Date
KATHER NOR   SE OT   Y    RE   A 100206   100206   100106
JOEY   NOR   CH OT   Y    RE   A 100206   100206   100106




Message
```

CAFI A – F01

- Confirm the data

```
CHANGE              CASH ASSISTANCE FINANCIAL ELIGIBILITY - CAFI        CAFI  A
Month 11 06                    4981   10 05 06
AU ID XXXX00184    Prog MA   Prog Type S    Med COA F01
                              Net Income Test (cont)
 Resources                         Standard – 30 1/3     265.97
   Resources Limit       1000.00   Dependent Care         43.33
   Total Resources        133.00   Net Earned Income     248.61
 Gross Income Test                 Net Unearned Income      .00
   Gross Income Limit     784.40   Deemed Income            .00
   Gross Earned Income    557.91   Allocated Income         .00
   Net Unearned Income       .00   Net Income            249.00
   Deemed Income             .00   Grant Amount             .00
   Allocated Income          .00   Recoupment Amount        .00
 Total Gross Income       557.91   Benefit Amount           .00
 Net Income Test                   Previous Benefit         .00
   Net Income Limit       424.00   Spenddown Amount
   Gross Earned Income    557.91   Medical Expense Amt
   Self Employ Work Exp      .00   Net Spenddown Amt
Bnft Eff Date 100206 Bnft Confirm     Reasons              Budgeting Method P
Notice Type 0011        Waive Timely Notice Period     Notice Override
Review Begin Dt 10 06  Review End Dt 04 07              Strat  2

Message

  13-note
```

DONE

- Commit to database

Examples:
Financial Changes in Ongoing Cases

Ongoing Recipient Reports New or Increased income

Example 1:

- Ongoing recipient begins working on June 1st.

- Receives first check on June 12th.

- Reports and verifies the change June 17th.

- The Case Manager acts on the change on June 17th.

- If the recipient is eligible on the trial budget, add the income to LIM for the ongoing month of July. Use representative amount (based on verification) multiplied by the appropriate conversion factor to determine income amount to budget. Determine if $30 & 1/3 needed for LIM.

- Timely notice expires July 1st.

- Change will be effective August.

Example 2:

- Ongoing recipient begins working on July 3rd.

- She receives her first check on July 11th.

- She reports and verifies the change on July 21st.

- The Case Manager acts on the change on July 29th.

- If the recipient is eligible on the trial budget, add the income to LIM for the ongoing month of August. Use the representative amount (based on verification) multiplied by the appropriate conversion factor to determine income to budget for August. Determine if $30 & 1/3 needed for LIM.

- Timely notice ends August 12th.

- Change will be effective September.

Examples:
Financial Changes in Ongoing Cases (continued)

Ongoing Recipient Reports Terminated or Decreased Deductions

Example 3:

- Ongoing recipient reports on July 9th that she will no longer pay child care.

- Last child care paid July 2nd.

- Case Manager acts on July 9th.

- Remove the child care deduction effective August.

Ongoing Recipient Reports Terminated or Decreased Income

Example 4:

- Ongoing recipient reports and verifies on March 23rd that she lost her job.

- She will receive her last check on April 6th in the amount of $103.

- The Case Manager acts on the change on March 23rd.

- The change is effective in April.

- Change the income in LIM for April to $103, the anticipated amount.

- Delete the income from LIM for the month of May.

Ongoing Recipient Reports New or Increased Deductions

Example 5:

- Ongoing recipient reports on December 28th that her child care has increased as of last week.

- The Case Manager acts on the change on January 2nd.

- Change the child care deduction for the ongoing month of January to the converted amount not to exceed the maximum.
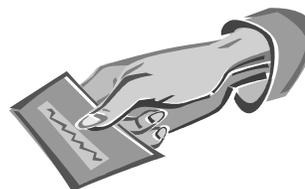
Proof of Medicaid Coverage

062 SUCCESS Notification
The Medicaid Card
Form 962
SUCCESS-issued Temporary Medicaid Card

TEMPORARY MEDICAID CARD – SUSAN NELSON WALK THROUGH

Background – Ms. Susan Nelson calls today to tell you she has a post-natal appointment and has not yet received her Medicaid card. You are able to locate her case information by using her SSN in the screening process.

Your Assignment – Print a temporary Medicaid card to give to Ms. Nelson.

MAIN MENU

- Select K

- Enter the Printer ID

- Press ENTER

```
                   ************************************
              **     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  K
                         Printer ID  $ZBA
                         System Date  10 05 06
                            Load ID   XXXX

      A. Assistance Unit/Client    H. Security         O. File Inquiry
      B. Supporting Units          I. Parameters       P. Vendor Files
      C. Employment Services       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 "?"
```

KMEN

- Select J

- Press ENTER

- Enter the AU ID #

- Press ENTER

```
            FINANCIAL MANAGEMENT ISSUANCE SUBMENU - KMEN        KMEN


                            Selection J

A. AU Pull/Hold Inquiry          AU ID
B. AU Pull/Hold Update

C. Issuance Request Inquiry      AU ID
D. DMP Issuance Request Update
E. Food Stamp Issn Request Update

F. Stop/Cancel/Reissue Request   AU ID          Iss Num
                                 Inst Type      Iss Dt

G. Stop/Cancel/Reis Approval Inq
H. Stop/Cancel/Reis Approval Upd  Iss Num          Approval Stat

I. Mass Cancel/Reissue Request    Instrument Type

J. MA ID Replacement              AU ID XXXX00188

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

MAID

- Review the information for accuracy

- Press ENTER to print the Medicaid card

```
UPDATE                  MA ID REPLACEMENT - MAID              MAID



                     AU ID  XXXX00188

           NELSON             SUSAN


            9019      CRESTLINE             WAY
            ATLANTA           GA   30303 0000


            MA ID Coverage Begin Date 10 01 06
            MA ID Coverage End Date   10 31 06


            First Day Liability          .00



Message
```

```
              GEORGIA DEPARTMENT OF HUMAN RESOURCES
              Division of Family and Children Services

              TEMPORARY MEDICAID CERTIFICATION

DEKALB County Department of Family and Children Services

This document is issued as proof that the persons listed below
have been determined by the Department of Family And Children
Services to be Medicaid eligible for the period 10/01/06 to
10/31/06.  This document has been issued because the original
Medicaid card has been reported as lost or stolen, and it serves
as proof of Medicaid Eligibility.

Medically Needy First Day Liability:


MEDICAID ELIGIBLE PERSONS                  MEDICAID ID NUMBER
----------------------------------------   ------------------
SUSAN       NELSON                              758000279P

IMPORTANT INFORMATION ON MANAGED CARE:
-------------------------------------   This document does not
contain managed care information normally found on the regular
Medicaid card.  If medical services are rendered on a "fee for
service" basis by a provider to an individual who has been
enrolled in managed care, the provider rendering the service may
have Medicaid reimbursement for the service denied by the
Department of Medical Assistance.  For more information on whether
the individuals listed on this document are enrolled in managed
care, call (800) 766-4456

DFCS Caseworkers Load Number: 1219

Telephone Number: (404) 370-5000

Date Issued: 10/05/06
```

Family Medicaid

Participant Guide
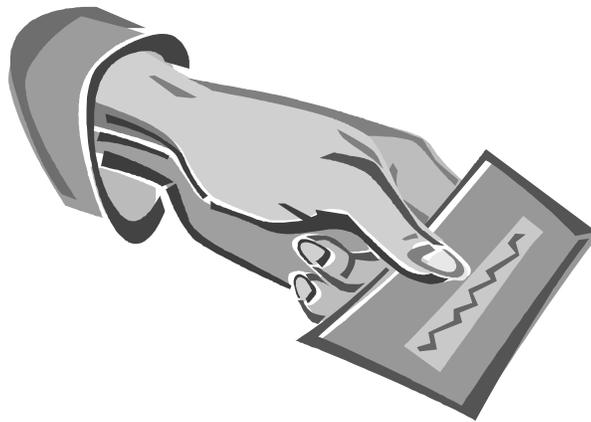
TRANSITIONAL MEDICAL ASSISTANCE

Objectives

☐   Participants will be able to determine how a LIM AU becomes eligible for Transitional Medical Assistance.

☐   Participants will be able to apply the non-financial requirements for TMA.

☐   Participants will be able to determine the eligibility period for TMA.

☐   Participants will be able to budget earned income for the additional six months of TMA.

☐   Participants will be able to process changes during the TMA eligibility period in SUCCESS.

☐   Participants will become familiar with the forms that are used to process TMA.

☐   Participants will be able to determine eligibility for TMA when a recipient reports untimely.

☐   Participants will be able to identify the correct type of notification the AU will receive.

Outline

TRANSITIONAL MEDICAL ASSISTANCE
SUMMARY OF POINTS OF ELIGIBILITY (MR 2166)

Eligibility Requirements: Ineligible for LIM due to new or increased earned income of an adult AU member or the loss of $30 or 1/3 deduction. AU must have correctly received LIM in 3 of the last 6 months prior to the first month of LIM ineligibility. TMA coverage begins the month that the AU loses LIM eligibility. TMA eligibility period is potentially 12 months divided into 2 consecutive 6 month periods. The TMA AU is comprised of only the individuals whose needs were included in the LIM AU at the time of LIM ineligibility.

TRANSITIONAL MEDICAL ASSISTANCE			
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
ADDR	**Residency (MR 2225)**	AU must continue to live in Georgia.	
STAT	**Living with a Specified Relative (MR 2245)**	All children must continue to be related to and living in the home of a specified relative. Accept A/R statement.	
DEM1	**Enumeration (MR 2220)**	Not required if already met under LIM.	
DEM1	**Age (MR 2255)**	Children must be under age 18.	Accept A/R statement.
DEM1	**Cooperation with Child Support Services (MR 2250)**	Not required.	
DEM2	**Citizenship/Alienage/ Identity (MR 2215)**	Must be a US citizen or lawfully admitted qualified alien. Refer to LIM policy requirements.	
DEM2	**Third Party Resources (MR 2230)**	Cooperation is required at approval for TMA as well as during both 6-month review periods.	
RES1	**Resources (MR 2301)**	Not counted.	
ERN1	**Income (MR 2166 and 2400)**	No income requirements for the initial 6-month extension of TMA. Earned income must be below 185% of the FPL during the additional 6-month extension.	Income must be verified by a third party source.

SUCCESS Screen	Criterion	Policy Summary	Verification Requirement
		TRANSITIONAL MEDICAL ASSISTANCE	
ERN2	**Budgeting (MR 2166 and 2667)**	The initial 6-months of TMA eligibility have no budgeting requirements. In the second 6-months for Quarterly Report Forms returned in the 7th and 10th months: ➢ Determine actual gross earned income for each month reported on the Quarterly Report Form (QRF), separately. Do not include unearned income. ➢ Determine actual dependent care paid for each month reported on the QRF if the gross countable earned income is greater than the TMA income limit. No maximum allowable dependent care amount. Subtract the reported dependent care expense from the gross earned income for each month. ➢ Compare the average net monthly earnings for each quarter to the TMA income limit for the AU size.	
UINC	**Application for Other Benefits (MR 2210)**	Not required.	

Criterion	Processing Standards Summary of the Policy
Initial 6-month Extension (MR 2166)	**Timely Report:** Begin TMA the month after timely notice expires for LIM ineligibility if AU meets criteria. **Untimely Report:** Determine when change should have been effective based on the 10 day reporting requirement (A/R has 10 days to report, Case Manager has 10 days to act, and 14 days for timely notice). Begin TMA the month after timely notice should have expired for LIM ineligibility if AU meets criteria.
Additional 6-month Extension (MR 2166)	AU must comply with QRF reporting requirements during the initial 6-month extension and continue to meet the TMA eligibility criteria to begin the additional 6-month extension period. AU must meet certain requirements to remain eligible for the additional 6-month extension period.

Transitional Medical Assistance (TMA)
Examples:

Ms. Mary Barber reports and verifies on 4/15 that she now has a new job. She will begin work on 4/25. She will earn $1200 gross per month and receive her first paycheck in May. She has received LIM for herself and her two children, Cindy (15) and Lucy (14) for the past 12 months. The Case Manager acts on 4/16.

   1.   What is the reason for LIM ineligibility?

   2.   Has Ms. Barber correctly received LIM in 3 out of the last 6 months prior to the month of LIM ineligibility?

   3.   Who will receive Medicaid in May?

   4.   For which months will they potentially receive Medicaid under TMA?

Georgia Department of Human Resources
TANF BUDGET SHEET

TMA EXAMPLE #1

Name of Grantee Relative **Mary Barber**	Number in AU **3**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change
AU ID Number **334455661**	Effective Month **May**	**C. Standard of Need Test**

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

A. Resource Test

Total Nonexempt Resources $ **0**
Resource Limit $ 1000
Eligible Based on Resources? ☑ Yes ☐ No

B. Gross Income Ceiling Test

Gross Income $ **1200**
(Plus deemed, less allocated income)
Gross Income Ceiling $ **784**
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes ☑ No

D. Eligibility/Payment Budget   **Ineligible for LIM due to increased earnings**

1. ☐ SON ☐ RSM Limit			
2. Earned Income			**Eligible for TMA May - April**
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

DETERMINING TMA ELIGIBILITY
WHEN WAGES ARE REPORTED UNTIMELY

Mr. Roberts has received LIM for himself and two children for seven months. On 7/15 he reports and verifies new employment which began 5/25; Mr. Roberts received his first check of $350.00 on 6/5 and has received this amount each week since this date. This is the amount that he expects to continue receiving each week.

Case # 345678900

Refer to the following budget:

1.   Complete a trial budget based on earnings of $350.00 weekly. The AU is ineligible for LIM ongoing. ($1516.65)

2.   Determine what should have happened using the 10+10+14 Rule.

3.   The first month of LIM ineligibility is August based on the 10+10+14 Rule and the financial determination completed for the ongoing month.

4.   Mr. Roberts has correctly received LIM in 3 of the 6 months preceding August.

5.   His potential 12 months of TMA are August through July.

Georgia Department of Human Resources
TANF BUDGET SHEET

LIM

Name of Grantee Relative **Mr. Roberts**	Number in AU **3**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change
AU ID Number **345678900**	Effective Month **August**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ __0__
Resource Limit $ 1000
Eligible Based on Resources? ☑ Yes ☐ No

B. Gross Income Ceiling Test

Gross Income $ **1516.65**
(Plus deemed, less allocated income)
~~Gross~~ Income Ceiling $ **784**
(Surplus)/Deficit $ _____
Eligible based on GIC test? ☐ Yes ☑ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **Ineligible for LIM due to increased earnings**

1. ☐ SON ☐ RSM Limit			
2. Earned Income			**$350.00** **x 4.3333** **$1516.65**
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

DETERMINING TMA ELIGIBILITY
WHEN WAGES ARE REPORTED UNTIMELY

Ms. Mays has received LIM for herself and one child since January. She has never worked while receiving LIM. She reports and verifies on August 3rd that she started working in June. A trial budget is completed for the ongoing month based on earnings of $165.00 weekly. Employment began June 15th and her first check was received on June 22nd. Ms. Mays has received $165.00 weekly since her first paycheck.

Case # 123456781

1.   The Case Manager completes a trial budget based on earnings of $165.00 weekly. The AU is LIM ineligible ongoing based on gross monthly wages of $714.99. See budget on next page.

2.   Determine what should have happened using the 10 + 10 + 14 Rule.

3.   First month of LIM ineligibility after a month of LIM eligibility is August, based on the 10+10+14 Rule and the financial determination completed for the ongoing month.

4.   Ms. Mays has correctly received LIM in 3 of the 6 months preceding August.

5.   Her potential 12 months of TMA are August through July.

Georgia Department of Human Resources
TANF BUDGET SHEET

LIM

Name of Grantee Relative **Ms. Mays**	Number in AU **2**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **123456781**	Effective Month **September**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ __0__

Resource Limit $ 1000

Eligible Based on Resources? ☑ Yes ☐ No

B. Gross Income Ceiling Test

Gross Income $ __714.99__

(Plus deemed, less allocated income)

~~Gross~~ Income Ceiling $ __659__

(Surplus)/Deficit $ _____

Eligible based on GIC test? ☐ Yes ☑ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **Ineligible for LIM due to increased earnings**

		Subtotals	
1. ☐ SON ☐ RSM Limit			
2. Earned Income			**$165.00** **x 4.3333** **$714.99**
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

Transitional Medical Assistance (TMA)
Examples:

Ms. Clara Cook has received LIM for herself and her son David (16) for the past 9 months. Ms. Cook is employed and earns $525 per month. Last month (June) was her 4th month of receiving the $30 and 1/3 deduction.

1.   What is the reason for LIM ineligibility?

2.   Has Ms. Cook received LIM in 3 out of the last 6 months prior to the month of LIM ineligibility?

3.   Who will receive Medicaid in July?

4.   For which months will they potentially receive Medicaid under TMA?

Georgia Department of Human Resources
TANF BUDGET SHEET

TMA EXAMPLE #2

Name of Grantee Relative **Clara Cook**	Number in AU **2**	Action Taken: ☑ Trial □ Initial
		□ Review ☑ Change

AU ID Number **123456789**	Effective Month **July**

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

A. Resource Test

Total Nonexempt Resources	$ ____0____
Resource Limit	$ 1000
Eligible Based on Resources?	☑ Yes □ No

B. Gross Income Ceiling Test

Gross Income	$ __525__
(Plus deemed, less allocated income)	
Gross Income Ceiling	$ __659__
Surplus/Deficit	$ _____
Eligible based on GIC test?	☑ Yes □ No

D. Eligibility/Payment Budget   **356**

1. ☑ SON □ RSM Limit			
2. Earned Income/**WAGES**	525.00		
Total Earned Income	525.00	**Subtotals**	
3. Less $90	90.00	435.00	
4. Less $30	30.00	405.00	
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income		405.00	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		405.00	405
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Ineligible for LIM due to the loss of the 1/3 deduction**		
15. Benefit Amount	**TMA eligible July - June**		

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$30 & 1/3 Low Income Medicaid Examples

Example #1

Ms. Wylie has received LIM for herself and three children for six months. Wages of $650/month and child care of $100/month have been included in the budget for each of the six months. She has not used the $30 & 1/3 deduction.

Example #2

On 4/7 Ms. Wylie verifies an increase in wages; her wages will increase to $750/month effective May. A trial budget must be completed to determine ongoing eligibility. Ms. Wylie needs to use the $30 & 1/3 deduction to remain LIM eligible.

Examples #3 & #4

On May 28, Ms. Wylie verifies that her wages for June will be only $300; she will be on leave without pay for 12 days. A/R states that her child care for June will be $50. Trial budget completed.

Example #5

A/R's $30 & 1/3 months are May through August; effective September Ms. Wylie receives the $30 deduction. Ms. Wylie previously reported an increase in child care expenses to $150/month. She remains LIM eligible.

Example #6

In April a trial budget is completed to determine ongoing eligibility for May after removing the $30 deduction. Ms. Wylie is ineligible for LIM; determine eligibility for TMA.

Georgia Department of Human Resources
TANF BUDGET SHEET

Example #1

Name of Grantee Relative **Ms. Wylie**	Number in AU **4**	Action Taken: ☑ Trial ☑ Initial ▫ Review ▫ Change

AU ID Number **223456781**	Effective Month **November**	**C. Standard of Need Test**

A. Resource Test		Gross Wages		$ **650**

A. Resource Test

Total Nonexempt Resources $ ___0___
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ▫ No

B. Gross Income Ceiling Test

Gross Income $ **650**
(Plus deemed, less allocated income)
Gross Income Ceiling $ **925**
Surplus/Deficit $_____
Eligible based on GIC test? ☑ Yes   ▫ No

C. Standard of Need Test

Gross Wages		$ **650**
Less Standard Deduction	$90	$ **560**
Less Child Care	$ **100**	$ **460**
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$ **460**
SON		$ **500**
Surplus/Deficit		$_____
Eligible for $30 + 1/3? **Need?**	▫ Yes	☑ No

D. Eligibility/Payment Budget   **500**

1. ☑ SON ▫ RSM Limit			
2. Earned Income/**WAGES**	**650.00**		
Total Earned Income	**650.00**	**Subtotals**	
3. Less $90	**90.00**	**560.00**	
4. Less $30 **Not Needed**		**560.00**	
5. Less 1/3		**560.00**	
6. Less Child Care	**100.00**	**460.00**	
7. Net Earned Income		**460.00**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**460.00**	**460**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **AU is LIM eligible without using $30 $ 1/3;**			
15. Benefit Amount **save deduction until it is needed**			

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TANF BUDGET SHEET

Example #2

Name of Grantee Relative **Ms. Wylie**	Number in AU **4**	Action Taken: ☑ Trial □ Initial □ Review ☑ Change	
AU ID Number **223456781**	Effective Month **May**	**C. Standard of Need Test**	

A. Resource Test	Gross Wages	$ **750**
Total Nonexempt Resources $ __0__	Less Standard Deduction $90	$ **660**
Resource Limit $1000	Less Child Care $ **100**	$ **560**
Eligible Based on Resources? ☑ Yes □ No	Plus Unearned Income $_____	$_____
B. Gross Income Ceiling Test	Plus Deemed Income $_____	$_____
Gross Income $ **750**	Less Allocation $_____	$_____
(Plus deemed, less allocated income)	Total	$ **560**
Gross Income Ceiling $ **925**	SON	$ **500**
Surplus/Deficit $_____	Surplus/Deficit	$_____
Eligible based on GIC test? ☑ Yes □ No	Eligible for $30 + 1/3? **Need?** ☑ Yes □ No	

D. Eligibility/Payment Budget   **500**

1. ☑ SON □ RSM Limit				
2. Earned Income/**WAGES**	**750.00**			
Total Earned Income	**750.00**	**Subtotals**		
3. Less $90	**90.00**	**660.00**		
4. Less $30	**30.00**	**630.00**		
5. Less 1/3	**210.00**	**420.00**		
6. Less Child Care	**100.00**	**320.00**		
7. Net Earned Income		**320.00**		
8. Plus Unearned Income				
9. Plus Child Support (Less $50 – Medicaid only)				
10. Plus Deemed Income				
11. Less Allocation				
12. Total Countable Income		**320.00**	**320**	
13. Surplus/Deficit (SON less line 12)				
14. Family Maximum	**LIM eligible;**			
15. Benefit Amount	**$30 + 1/3 months: May, June, July, and August**			

> **A/R was eligible for $30 & 1/3 but had not used it. Now that her wages have increased, she needs to use her $30 & 1/3 to remain eligible for LIM.**

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Georgia Department of Human Resources
TANF BUDGET SHEET

Example #3

Name of Grantee Relative **Ms. Wylie**	Number in AU **4**	Action Taken: ☑ Trial □ Initial □ Review ☑ Change

AU ID Number **223456781**	Effective Month **June**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ _____ **0** _____
Resource Limit $ 1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ _____ **300** _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____ **925** _____
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes   □ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   **500**

1. ☑ SON □ RSM Limit				
2. Earned Income/**WAGES**	**300.00**			
Total Earned Inc		**300.00**	Subtotals	
3. Less $90		**90.00**	**210.00**	
4. Less $30		**30.00**	**180.00**	
5. Less 1/3		**60.00**	**120.00**	
6. Less Child Ca		**50.00**	**70.00**	
7. Net Earned In			**70.00**	
8. Plus Unearned Income				
9. Plus Child Support (Less $50 – Medicaid only)				
10. Plus Deemed Income				
11. Less Allocation				
12. Total Countable Income			**70.00**	**70**
13. Surplus/Deficit (SON less line 12)				
14. Family Maximum	**LIM eligible**			
15. Benefit Amount				

Text box (overlapping table):

The $30 & 1/3 count began with May and must continue unless:
1) **the $90 deduction exhaust the wages,**
2) **wages terminate, or**
3) **the case is closed and a benefit month is missed**

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Georgia Department of Human Resources
TANF BUDGET SHEET

Example #4

Name of Grantee Relative **Ms. Wylie**	Number in AU **4**	Action Taken: ☑ Trial □ Initial □ Review ☑ Change

AU ID Number **223456781**	Effective Month **June**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ _____**0**_____
Resource Limit $ 1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ _____**0**_____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____**925**_____
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes   □ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   **500**

		Subtotals	
1. ☑ SON □ RSM Limit			
2. Earned Income/**WAGES**			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income		**0**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**0**	**0**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**LIM eligible**		
15. Benefit Amount			

> **If A/R were to receive $0 wages in June, the $30 & 1/3 count would stop.**
>
> **The $30 & 1/3 count would begin over with the month it is needed for the AU to be LIM eligible.**

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Georgia Department of Human Resources
TANF BUDGET SHEET

Example #5

Name of Grantee Relative **Ms. Wylie**	Number in AU **4**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **223456781**	Effective Month **September**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ _____**0**_____
Resource Limit $ 1000
Eligible Based on Resources? ☑ Yes ☐ No

B. Gross Income Ceiling Test

Gross Income $ _____**750**_____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____**925**_____
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes ☐ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **500**

1. ☑ SON ☐ RSM Limit			
2. Earned Income/**WAGES**	750.00		
Total Earned Income	**750.00**	**Subtotals**	
3. Less $90	**90.00**	**660.00**	
4. Less $30	**30.00**	**630.00**	
5. Less 1/3 **No longer eligible**		**630.00**	
6. Less Child Care	**150.00**	**480.00**	
7. Net Earned Income		**480.00**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**480.00**	**480**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **LIM eligible**			
15. Benefit Amount			

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Georgia Department of Human Resources
TANF BUDGET SHEET

Example #6

Name of Grantee Relative **Ms. Wylie**	Number in AU **4**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change
AU ID Number **223456781**	Effective Month **May**	**C. Standard of Need Test**

A. Resource Test		C. Standard of Need Test		
Total Nonexempt Resources $ __0__		Gross Wages		$_____
Resource Limit $1000		Less Standard Deduction	$90	$_____
Eligible Based on Resources? ☑ Yes □ No		Less Child Care	$_____	$_____
B. Gross Income Ceiling Test		Plus Unearned Income	$_____	$_____
Gross Income $ __750__		Plus Deemed Income	$_____	$_____
(Plus deemed, less allocated income)		Less Allocation	$_____	$_____
Gross Income Ceiling $ __925__		Total		$_____
Surplus/Deficit $_____		SON		$_____
Eligible based on GIC test? ☑ Yes □ No		Surplus/Deficit		$_____
		Eligible for $30 + 1/3? □ Yes □ No		

D. Eligibility/Payment Budget			**500**
1. ☑ SON □ RSM Limit			
2. Earned Income/**WAGES**	750.00		
Total Earned Income	**750.00**	**Subtotals**	
3. Less $90	**90.00**	**660.00**	
4. Less $30	**Exhausted**		
5. Less 1/3			
6. Less Child Care	**150.00**	**510.00**	
7. Net Earned Income		**510.00**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**510.00**	**510**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **Ineligible for LIM – due to loss of the $30 deduction**			
15. Benefit Amount			

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Low Income Medicaid Examples

1. Ms. Smith has been receiving LIM for three months. The AU includes Ms. Smith and her two children, Nancy and David. A/R reports and verifies new employment on 9/16 that began on 9/14. She works 25 hours per week, earns $7.00 per hour, and is paid weekly on Fridays. Her first check is expected on 9/25. A/R has never worked while receiving LIM. A/R pays childcare of $25.00 per week. Their only resource is a savings account in the amount of $95.

    a. Will the AU remain eligible for LIM?

    b. If Ms. Smith continues to receive LIM, uses $30 & 1/3 deduction for October through January, and her circumstances remain the same, what happens to her case effective February?

Georgia Department of Human Resources
TANF BUDGET SHEET

LIM Example #1a

Name of Grantee Relative **Ms. Smith**	Number in AU **3**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **234567801**	Effective Month **October**	**C. Standard of Need Test**

A. Resource Test		Gross Wages		**$ 758.32**

Total Nonexempt Resources $ __95__

Resource Limit $1000

Eligible Based on Resources? ☑ Yes   ☐ No

Less Standard Deduction	$90	**$ 668.32**
Less Child Care	$ __108.33__	**$ 559.99**
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____

B. Gross Income Ceiling Test

Gross Income $ __758.32__

(Plus deemed, less allocated income)

Gross Income Ceiling $ __784__

Surplus/Deficit $_____

Eligible based on GIC test? ☑ Yes   ☐ No

Total	**$ 559.99(560)**
SON	**$ 424**
Surplus/Deficit	$_____
Need? Eligible for $30 + 1/3? ☑ Yes ☐ No	

D. Eligibility/Payment Budget			**424**	
1. ☑ SON ☐ RSM Limit				
2. Earned Income/**WAGES**	758.32			
Total Earned Income	758.32	**Subtotals**		
3. Less $90	90.00	668.32		
4. Less $30	30.00	638.32		
5. Less 1/3	212.77	425.55		
6. Less Child Care	108.33	317.22		
7. Net Earned Income		317.22		
8. Plus Unearned Income				
9. Plus Child Support (Less $50 – Medicaid only)				
10. Plus Deemed Income				
11. Less Allocation				
12. Total Countable Income		317.22	317	
13. Surplus/Deficit (SON less line 12)				
14. Family Maximum **Eligible for LIM**				
15. Benefit Amount				

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Georgia Department of Human Resources
TANF BUDGET SHEET

LIM Example #1b

Name of Grantee Relative **Ms. Smith**	Number in AU **3**	Action Taken: ☑ Trial □ Initial □ Review ☑ Change

AU ID Number **234567801**	Effective Month **February**

A. Resource Test

Total Nonexempt Resources $ __**95**__
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ __**758.32**__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __**784**__
Surplus/Deficit $_____
Eligible based on GIC test? ☑ Yes   □ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget | | | **424** |

1. ☑ SON □ RSM Limit			
2. Earned Income/**WAGES**	758.32		
Total Earned Income	**758.32**	**Subtotals**	
3. Less $90	**90.00**	**668.32**	
4. Less $30	**30.00**	**638.32**	
5. Less 1/3			
6. Less Child Care **No longer eligible**	**108.33**	**529.99**	
7. Net Earned Income		**529.99**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**529.99**	**530**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **LIM ineligible due to loss of 1/3 deduction**			
15. Benefit Amount			

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Low Income Medicaid Examples
(continued)

2.   Ms. Johnson receives LIM for herself and her four children. She reports and verifies on 6/4 that she started a new job on 6/1. She will work 28 hours per week and earn $7.50 per hour. She will pay $150 per month in child care for all the children. There is no other income. The Case Manager acts on 6/4.

      a.   Will the AU remain eligible for LIM?

      b.   If eligible, what are the $30 & 1/3 months?

      c.   Will the AU remain eligible for LIM after the four months of $30 & 1/3?

      d.   Under what COA will this AU receive Medicaid?

      e.   How long is the eligibility period for this class of Medicaid?

Georgia Department of Human Resources
TANF BUDGET SHEET

LIM Example #2

Name of Grantee Relative **Ms. Johnson**	Number in AU **5**	Action Taken: ☑ Trial □ Initial □ Review ☑ Change

AU ID Number **234567711**	Effective Month **July**	**C. Standard of Need Test**

A. Resource Test		

Total Nonexempt Resources $ ____**0**____
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

Gross Wages		$ **909.99**
Less Standard Deduction	$90	$ **819.99**
Less Child Care	$ **150**	$ **669.99**
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$ **669.99**
SON		$ **573**
Surplus/Deficit **Need?**		$_____
Eligible for $30 + 1/3?	☑ Yes	□ No

B. Gross Income Ceiling Test

Gross Income $ **909.99**
(Plus deemed, less allocated income)
Gross Income Ceiling $ **1060**
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes   □ No

D. Eligibility/Payment Budget			**573**
1. ☑ SON □ RSM Limit			
2. Earned Income/**WAGES**	**909.99**		
Total Earned Income	**909.99**	**Subtotals**	
3. Less $90	**90.00**	**819.99**	
4. Less $30	**30.00**	**789.99**	
5. Less 1/3	**263.33**	**526.66**	
6. Less Child Care	**150.00**	**376.66**	
7. Net Earned Income		**376.66**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**376.66**	**378**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Eligible for LIM**		
15.Benefit Amount			

$30 & 1/3 months are July - October

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Georgia Department of Human Resources
TANF BUDGET SHEET

LIM Example #2

Name of Grantee Relative **Ms. Johnson**	Number in AU **5**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **234567711**	Effective Month **November**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ _____0_____
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ __909.99__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __1060__
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes   ☐ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **573**

1. ☑ SON ☐ RSM Limit			
2. Earned Income/**WAGES**	909.99		
Total Earned Income	**909.99**	**Subtotals**	
3. Less $90	**90.00**	**819.99**	
4. Less $30	**30.00**	**789.99**	
5. Less 1/3			
6. Less Child Care	**150.00**	**639.99**	
7. Net Earned Income		**639.99**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**639.99**	**640**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Ineligible for LIM**		
15.Benefit Amount	**TMA Eligible November - October**		

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INCREASED INCOME – ANTONIO KLEIN
WALK THROUGH

Background – On October 5th, Mr. Klein calls to report a change. He has received information today that his hourly wage has increased to $10.00 an hour and he is now working 40 hours a week.

After you congratulate Mr. Klein on his accomplishments, you tell him that you are sending him a form to obtain verification for his case. Mr. Klein states his General Manager, Mr. Roy Nelson, stated he was faxing a copy of the promotion letter. You ask him if there are any other changes such as anyone moving in or out of his home, or any other income changes. He states there are no other changes other than his income.

You check your mail box and there is a fax from Mr. Nelson regarding the increase in pay for Mr. Klein.

Enter the reported change on SUCCESS.

Home Depot

233 Home Depot Lane
Forsyth, GA 31029
478-555-1254

To: Antonio Klein

From: Roy Nelson, General Manager *RN*

Date: 10/5/06

RE: Promotion

I am pleased to inform you that you have been promoted to the position of Assistant Department Manager. Your duties for this position are outlined on the attached document.

Commensurate with the duties assigned for this position, your promotion also includes a pay increase. Effective 11/1/06, your hourly rate will increase to $10.00 per hour and you are scheduled to work 40 hours per week.

Please review the attached duties and contact my office no later than 10/7/06 to discuss your acceptance of this position.

Congratulations and we look forward to working with you in your new position as Assistant Department Manager.

AMEN

- Select R

- Enter LIM AU ID #

```
          ASSISTANCE UNIT/CLIENT SUBMENU - AMEN               AMEN

                      Selection R
           AU ID XXXX00197          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
```

ADDR

- Access NARR to enter documentation

- Fastpath to ERN2

ERN2

- Update representative amount and verification field

- Access ADT to enter documentation

- Fastpath to DONE

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

Client Name ANTONIO    KLEIN                 Client ID XXXX00292

Employer Name Walmart

               Avg Hrs 40    Freq wk   Day Week Pd TH   Extra Pay

Del

   Amt 1    V    Amt 2    V    Amt 3    V    Amt 4    V     Extra    V
   400.00   LE
   ------------------------- 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
```

ELIG – 11/06

- If correct, confirm the data

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

 AU ID XXXX00197    Prog MA    Prog Type F   Med COA F07
 Confirm Y

 AU      AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons     Date       Date    Date     Date     Type  End Date
 A                   100506    100206   100106
---------------------------------------------------------------------------
First   Last  Rel V  Mand Finl  --Stat-- Rsn  Appl    Begin  Pd Thru  Penalty
Name    Name         Incl Resp   Date         Date    Date   Date   T  Date
ANTONI KLE    SE OT   Y    RE    A 100506      100206  100106
TISHA  KLE    SP OT   Y    RE    A 100506      100206  100106
KARMEN KLE    CH OT   Y    RE    A 100506      100206  100106
CHARLE KLE    CH OT   Y    RE    A 100506      100206  100106




Message
```

CAFI – 11/06

- Review the POE end date

- If correct, confirm the data

```
 CHANGE              CASH/MA FINANCIAL ELIGIBILITY - CAFI           CAFI    A
 Month 11 06
 AU ID XXXX00197   Prog MA   Prog Type F      Med COA  F07
                                Net Income Test (cont)
 Resources                        Standard - 30 1/3          .00
    Resource Limit             .00   Dependent Care          .00
    Total Resources            .00   Net Earned Income       .00
 Gross Income Test                   Net Unearned Income     .00
    Gross Income Limit         .00   Deemed Income           .00
    Gross Earned Income        .00   Allocated Income        .00
    Net Unearned Income        .00   Net Income              .00
    Deemed Income              .00   Grant Amount            .00
    Allocated Income           .00   Recoupment Amount       .00
 Total Gross Income            .00   Benefit Amount          .00
 Net Income Test                     Previous Benefit        .00
    Net Income Limit           .00   Spenddown Amount
    Gross Earned Income        .00   Medical Expense Amt
    Self Employ Work Exp       .00   Net Spenddown Amt
 Bnft Eff Date 100506 Bnft Confirm  Y  Reasons            Budgeting Method P
 Notice Type 0003        Waive Timely Ntc Period            Notice Override
 Review Begin Date 09 06    Review End Date 04 07           Strat 1
 Message

   13-note
```

DONE

- Commit to the database

AMEN

- Select R

ADDR

- Fastpath to MISC

MISC

- Enter Y in COA Correct field to confirm the Medicaid Extended Start Date

- Access ADT to enter documentation

- Fastpath to DONE

```
CHANGE                 AU NON-FINANCIAL MISCELLANEOUS - MISC           MISC    A
Month 11 06                      5991   10 05 06

 HOH Name ANTONIO       KLEIN                    Client ID XXXX00292
 AU ID XXXX00197    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
                                                              11 06     Y


 ----- Review ----    Auto   Lump Sum                        Delay  QMB  RSM
 Compl  Mand  Last  Reasgn   Remain                          Rsn    Ovr  Elig
        Std   Type   Ovr     Amount                                      Ovr
                      Y
 Sched Interview         QC Penalty End Date
 Del     Unit Number 179502    Inquiry Date 10 05 06      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

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

```
UPDATE                    REMARKS - REMA                     REMA
                                                              01
  ******************************* TMA/F07 *******************************
  10/05/2006 12:35 PM Family Medicaid Training 555-555-5555
  For F07, months of eligibility :_11/06____ to :_10/07_____
  Document reason for LIM ineligibility:__INCREASED WAGES – AR NOW EARNS
  $10/HR @ 40 HRS/WK_____




                                                              More
  MESSAGE

  13-bott
```

ELIG – 11/06

- If correct, confirm the data

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

 AU ID XXXX00197    Prog MA    Prog Type F    Med COA F07
 Confirm Y

  AU     AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons     Date       Date    Date     Date     Type  End Date
  A                  100506  100206  100106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date          Date    Date   Date    T  Date
 ANTONI KLE   SE OT   Y    RE   A 100506       100206 100106
 TISHA  KLE   SP OT   Y    RE   A 100506       100206 100106
 KARMEN KLE   CH OT   Y    RE   A 100506       100206 100106
 CHARLE KLE   CH OT   Y    RE   A 100506       100206 100106




 Message
```

CAFI – 11/06

- Review the POE end date

- If correct, confirm the data

```
CHANGE              CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
Month 11 06
AU ID XXXX00197    Prog MA   Prog Type F       Med COA  F07
                               Net Income Test (cont)
Resources                       Standard - 30 1/3        .00
   Resource Limit        .00    Dependent Care           .00
   Total Resources       .00    Net Earned Income        .00
Gross Income Test               Net Unearned Income      .00
   Gross Income Limit    .00    Deemed Income            .00
   Gross Earned Income   .00    Allocated Income         .00
   Net Unearned Income   .00    Net Income               .00
   Deemed Income         .00    Grant Amount             .00
   Allocated Income      .00    Recoupment Amount        .00
Total Gross Income       .00    Benefit Amount           .00
Net Income Test                 Previous Benefit         .00
   Net Income Limit      .00    Spenddown Amount
   Gross Earned Income   .00    Medical Expense Amt
   Self Employ Work Exp  .00    Net Spenddown Amt
Bnft Eff Date 100506 Bnft Confirm  Y  Reasons            Budgeting Method P
Notice Type 0003         Waive Timely Ntc Period          Notice Override
Review Begin Date 11 06  Review End Date 10 07             Strat 2
Message
  13-note
```

INCREASED INCOME – KELLY LANDON
INDEPENDENT STUDY

Background – Ms. Landon calls to report a change on October 5th.   She has received information today that United Insurance has finished reorganizing and is promoting her to a manager position.

After you congratulate Ms. Landon on her accomplishments, you tell her that you are sending her a form to obtain verification for her case. Ms. Landon states her supervisor, Ms. Joan Smith, stated she would fax a signed letter regarding this change. You ask her if there are any other changes such as anyone moving in or out of her home, any other income such as child support, or any changes in child care expenses. She states there are no other changes other than her income. She will continue to pay childcare costs of $30 per week to Boys Clubs of America for Robert.

You check your mail box and there is a fax from Ms. Smith regarding Ms. Landon's promotion.

Enter the reported change on SUCCESS.

UNITED

Auto

Life　　Fire

INSURANCE
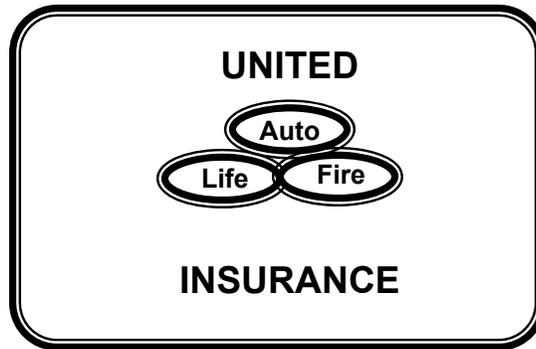
October 5, 2006

To Whom It May Concern:

Kelly Landon has been promoted to the position of Office Manager of our Atlanta branch office. She will begin this position on 11/1/06 and will earn $550.00 per week. This is a full-time position and Ms. Landon will work 40 hours per week.

If you have any questions, feel free to call.

Sincerely,

Joan Smith

Joan Smith
District Manager

5301 Piedmont Road, NE • Suite 235 • Atlanta, GA 30303
404-230-3694

TMA NOTIFICATION AND REPORTING
(MR 2166)

Month	SUCCESS	Case Manager Action	Information
1st	Sends notice to AU that LIM closed but Medicaid continues. Sets the extended MA start date for TMA to the ongoing month. Sends an alert to MMIS.		
3rd	Send the 1st QRF to the AU on the 15th of the month requesting actual gross income and child care expenses paid for months 1, 2 and 3.		All income reported on the QRF must be verified by third party source. Accept A/R statement for child care expense incurred unless questionable.
4th	If the QRF or QRF information is not received by the 5th calendar day SUCCESS sends a TMA Quarterly Report Follow Up Notice giving the AU until the 21st to provide the completed QRF or QRF information.* SUCCESS terminates TMA effective the 7th month if QRF information is never reported. Complete CMD.	When AU complies with reporting requirements of the 4th month, Case Manager must enter the QRF information on the TMA Income screen.*	This information (provided or not) has no impact on the 1st six months of TMA. This reporting criterion is required to establish the 2nd six months of TMA.
6th	Sends QRF to the AU on the 15th of the month requesting actual gross income and child care expenses paid for months 4, 5 and 6.		All income reported on the QRF must be verified by third party source. Accept A/R statement for child care expense incurred unless questionable.

Month	SUCCESS	Case Manager Action	Information
7th	If the QRF or QRF information is not received by the 5th calendar day SUCCESS sends a TMA Quarterly Report Follow Up Notice giving the AU until the 21st to provide the completed QRF or QRF information.* SUCCESS terminates TMA effective the 8th month if QRF information is never reported. Complete CMD.	When the AU complies with the reporting requirements of the 7th month, Case Manager must enter the QRF information on the TMA Income screen and confirm eligibility for the next three months (3rd quarter).*	A financial determination will be completed. The earned income must be equal to or less than the TMA AU limit. If eligible, coverage extends through next quarter. If ineligible, SUCCESS terminates TMA and trickles to a lower Medicaid class. Complete CMD.
9th	Sends QRF to the AU on the 15th of the month requesting actual gross income and child care expenses paid for months 7, 8 and 9.		All income reported on the QRF must be verified by third party source. Accept A/R statement for child care expense incurred unless questionable.
10th	If the QRF or QRF information is not received by the 5th calendar day SUCCESS sends a TMA Quarterly Report Follow Up Notice giving the AU until the 21st to provide the completed QRF or QRF information.* SUCCESS terminates TMA effective the 11th month if QRF information is never reported. Complete CMD.	When the AU complies with reporting requirements of the 10th month, FICM must enter the QRF information on the TMA Income screen and confirm eligibility for the last three months. (4th quarter).*	A financial determination will be completed. The earned income must be equal to or less than the TMA AU limit. If eligible, TMA coverage continues. If ineligible, SUCCESS terminates TMA and trickles to a lower Medicaid class. Completes CMD.
11th			
12th	CMD is completed by SUCCESS and will trickle to another COA if possible. Sends information to MMIS for each active A/R in the AU, sends an alert to the Case Manager and a notice to the AU.		

* Refer to MR 2166-8 and 9 if the QRF received is incomplete or Good Cause exists.

QUARTERLY REPORT FORM

SUCCESS sends the customer the following letter to explain their TMA eligibility:

INQUIRY   NOTICE CONTENT - NCON   NCON

 Client Name GEORGIA C CUSTOMER   Client ID 010101010

0032 -NOTICE OF ELIGIBILITY FOR EXTENDED MEDICAID BENEFITS

You are eligible to receive Medicaid for 6 months under the Transitional Medical Assistance Program, from 11/01/0X through 04/30/0X. Medicaid will continue for the persons listed below:

GEORGIA C CUSTOMER   010101010P
 STATE CUSTOMER 20202020P

You may be eligible to receive 6 additional months of Medicaid under this program, from 05/01/0X through 10/31/0X. If so, a report form will be mailed to you in 01/0X and must be returned by 02/05/0X. On this form you must report your family's gross earnings and child care cost for the first 3 months that you received Transitional Medical Assistance. You may either complete the report form or call your caseworker to report this information. If you do not report by the date shown above, you and your family may not receive the additional months of Medicaid benefits.

NOTE: Your eligibility for Transitional Medical Assistance will end if any of the following situations occurs:

-    your family moves out of state
-    there is no longer a child under age 18 in your home
-    a court determines that you committed fraud during any
     one of the last six months you received TANF.

INFORMATION ABOUT TRANSITIONAL CHILD CARE
You may be eligible to receive assistance to help pay your child care cost. To see if you are eligible, contact your caseworker for an application form for the Transitional Child Care program. If you do not have child care costs now, you may apply for help with child care when you start paying this cost.

The first QRF is sent by SUCCESS in the third month of TMA eligibility and due back by the 5th of the fourth month:

INQUIRY   NOTICE CONTENT - NCON   NCON

Client Name GEORGIA C CUSTOMER   Client ID 010101010

0058 - NOTICE OF TRANSITIONAL MEDICAL ASSISTANCE

You are receiving Medicaid under the Transitional Medical Assistance program. This entitles you to free Medicaid services just as you received under Low Income Medicaid.

To continue receiving Medicaid, you must meet certain requirements. Failure to provide the information requested below by the due date may STOP your Medicaid benefits.

You may be eligible for an additional six months extension of Transitional Medical Assistance 05/01/0X through 10/31/0X.

For each month listed on the attached report form, you MUST report your family's gross earnings and child care cost BUT you do not have to provide proof of this information. You MAY complete the attached report form OR call your caseworker and verbally report this information to her/him.
0058 QRF Form was sent to AU 121212121 on 1/15/0X.

SUCCESS sends the following notice if the QRF is not returned or information is not entered on SUCCESS by the 5th of the following month:

INQUIRY   NOTICE CONTENT - NCON   NCON

Client Name GEORGIA C CUSTOMER   Client ID 010101010

0053 - NOTICE OF TERMINATION
    DUE TO NON-RECEIPT OF QRF   AU 121212121

As a Medicaid recipient under the Transitional Medical Assistance program, you are required to complete and return a form called a QRF every 3 months. A QRF is a Quarterly Report Form that collects information about your income and child care expenses.

We did not receive a QRF from you this month, so your benefits will be terminated on 02/28/0X. A second QRF is being sent to you in another envelope. Please complete it and return it to your County Department of Family Children Service office as soon as possible if you have not already done so.

If you fail to provide the above information by 02/21/0X, your Transitional Medical Assistance will be TERMINATED effective 04/30/0X. Let your caseworker know if you had a reason for not reporting this information on time.

Peachcare for Kids offers medical assistance similar to Medicaid. Children under age of 19 may be eligible for Peachcare for Kids, please call 1-877-GAPEACH (427-3224) for application information.

The following notice is sent once the QRF is completed in SUCCESS:

INQUIRY   NOTICE CONTENT - NCON   NCON

 Client Name GEORGIA C CUSTOMER   Client ID 010101010

1034 - REVIEW RESULTS   AU 121212121

We have completed our review of your case on 02/17/0X and determined that you are still eligible for benefits. Your period of eligibility is from the first day of 05/0X to the last day of 10/0X. At the end of that period we will once again review your case.

You are eligible for MEDICAID. If you are on a medical spenddown, we cannot pay for your medical care until your spenddown is met. A separate notice will tell you about your spenddown.

You are required to report changes to us within ten days of the change. A change in your situation may result in a change in the amount of your benefit or in your eligibility.

QRF UPDATE – ANTONIO KLEIN
WALK THROUGH

Background – Mr. Antonio Klein's LIM case trickled to TMA effective 11/06. A Quarterly Report Form was mailed to Mr. Klein on 1/15 with a due date of 2/5/07. Mr. Klein returned his first QRF on 2/4/07.

Review the earned income and childcare sections of Mr. Klein's QRF and enter the information in SUCCESS.

A. NAME OF PERSON WHO WORKED:					Antonio Klein				
EMPLOYER:					Home Depot				
NAME OF PERSON WHO PAID CHILD CARE:					N/A				
CHILD CARE PROVIDER:									
IS THE PERSON WHO WORKED A FULL TIME STUDENT?					NO				
IF YES, WHERE IS THIS PERSON IN SCHOOL?									

MONTH OF NOVEMBER 2006					MONTH OF DECEMBER 2006				
EARNINGS			CHILD	CARE	EARNINGS			CHILD	CARE
DATE PAID	GROSS PAY	TIPS	COSTS		DATE PAID	GROSS PAY	TIPS	COSTS	
11/6/2006	400	0	11/6/2006	0	12/4/2006	400	0	12/4/2006	0
11/13/2006	400	0	11/13/2006	0	12/11/2006	400	0	12/11/2006	0
11/20/2006	400	0	11/20/2006	0	12/18/2006	400	0	12/18/2006	0
11/27/2006	400	0	11/27/2006	0	12/23/2006	400	0	12/23/2006	0

MONTH OF JANUARY 2007						
EARNINGS			CHILD	CARE	SIGNATURE OF EMPLOYER	
DATE PAID	GROSS PAY	TIPS	COSTS		*Roy Nelson*	
1/2/2007	400	0	1/2/2007	0	PHONE	*478-555-1254*
1/9/2007	400	0	1/9/2007	0	SIGNATURE OF PERSON PROVIDING CHILD CARE	
1/16/2007	400	0	1/16/2007	0		
1/23/2007	400	0	1/23/2007	0	PHONE	
1/30/2007	400	0	1/30/2007	0		

AMEN

- Select S

- Enter Mr. Klein's TMA AU ID #

TMAI

- Enter 2/4/07 to indicate the date the QRF was received

- Enter C to indicate the QRF was returned completed

- Enter the gross wages earned for the months listed

- Enter QR as the verification code

- Enter childcare costs as reported on the QRF; verified by AR's statement

- Press ENTER

```
QRF CHNGE                    TMA INCOME - TMAI                      TMAI   A
Month 02 07

 HOH Name ANTONIO     KLEIN                  Client ID XXXX00292
 AU ID XXXX00197


      Date         QRF        QRF       Unemployed    RSN QRF
      QRF          Status     Good      Good Cause    Incomplete
      Received     Code       Cause
        ?            ?


      QRF Months   Gross Inc  V     Dep Care     V


       01 07         ?
       12 06         ?
       11 06         ?


 Message 0013 01
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
```

```
QRF CHNGE                      TMA INCOME - TMAI                      TMAI    A
Month 02 07

 HOH Name ANTONIO     KLEIN                   Client ID XXXX00292
 AU ID XXXX00197


       Date          QRF        QRF       Unemployed    RSN QRF
       QRF           Status     Good      Good Cause    Incomplete
     Received        Code       Cause
     02 04 07         C


     QRF Months    Gross Inc   V     Dep Care     V


      01 07        2000.00     qr        0        cs
      12 06        1600.00     qr        0        cs
      11 06        1600.00     qr        0        cs


 Message 0013 01
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
```

QRF UPDATE – KELLY LANDON
INDEPENDENT STUDY

Background – Ms. Kelly Landon's LIM case trickled to TMA effective 11/06. A Quarterly Report Form was mailed to Ms. Landon on 1/15 with a due date of 2/5/07. Ms. Landon returned her first QRF on 2/4/07.

Review the earned income and childcare sections of Ms. Landon's QRF and enter the information on the manual SUCCESS screen.

A. NAME OF PERSON WHO WORKED:					Kelly Landon				
EMPLOYER:					United Insurance				
NAME OF PERSON WHO PAID CHILD CARE:					Kelly Landon				
CHILD CARE PROVIDER:					Boys Club of America				
IS THE PERSON WHO WORKED A FULL TIME STUDENT?					NO				
IF YES, WHERE IS THIS PERSON IN SCHOOL?									
MONTH OF NOVEMBER 2006					**MONTH OF DECEMBER 2006**				
EARNINGS			CHILD	CARE	EARNINGS			CHILD	CARE
DATE PAID	GROSS PAY	TIPS	COSTS		DATE PAID	GROSS PAY	TIPS	COSTS	
11/6/2006	550	0	11/6/2006	30	12/4/2006	550	0	12/4/2006	30
11/13/2006	550	0	11/13/2006	30	12/11/2006	550	0	12/11/2006	30
11/20/2006	550	0	11/20/2006	30	12/18/2006	550	0	12/18/2006	30
11/27/2006	550	0	11/27/2006	30	12/23/2006	550	0	12/23/2006	30

MONTH OF JANUARY 2007						
EARNINGS			CHILD	CARE	SIGNATURE OF EMPLOYER	
DATE PAID	GROSS PAY	TIPS	COSTS		*Joan Smith*	
1/2/2007	550	0	1/2/2007	30	PHONE	
1/9/2007	550	0	1/9/2007	30	SIGNATURE OF PERSON PROVIDING CHILD CARE	
1/16/2007	550	0	1/16/2007	30	_____	
1/23/2007	550	0	1/23/2007	30	PHONE	
1/30/2007	550	0	1/30/2007	30	_____	

TMAI

- Enter the data from QRF submitted on 2/4/07

```
QRF CHNGE                 TMA INCOME - TMAI                   TMAI    A
Month 02 07

 HOH Name KELLY      LANDON               Client ID XXXXXXXXX
 AU ID XXXXXXXXX


        Date          QRF      QRF      Unemployed   RSN QRF
        QRF          Status    Good     Good Cause   Incomplete
      Received        Code     Cause

       _____        _____


      QRF Months   Gross Inc   V    Dep Care    V

        01 07      _____   ___   _____   ___

        12 06      _____   ___   _____   ___

        11 06      _____   ___   _____   ___




 Message 0013 01
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
```

TMAI – 2/07

```
QRF CHNGE                   TMA INCOME - TMAI                    TMAI    A
Month 02 07

 HOH Name KELLY      LANDON                  Client ID XXXXXXXXX
 AU ID XXXXXXXXX


        Date          QRF        QRF       Unemployed    RSN QRF
        QRF          Status      Good      Good Cause    Incomplete
      Received        Code       Cause
      02 04 07         C


      QRF Months    Gross Inc  V     Dep Care    V


       01 07        2750.00    qr      150.00    cs
       12 06        2200.00    qr      120.00    cs
       11 06        2200.00    qr      120.00    cs


 Message 0013 01
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
```

TMA Review

1. TMA may be the appropriate COA when an AU becomes ineligible for LIM due to one of the following reasons:

    _____

    _____

    _____

2. The potential time period for TMA eligibility is _____ _____. This time period is divided into _____ _____ and the _____.

3. In order for TMA to be appropriate, the AU must have correctly received LIM for _____ of the last _____ months.

4. The AU must have included a child under the age of _____.

5. TMA is not the appropriate Medicaid to CMD for a LIM AU that has increased child support income.
    True or False

Family Medicaid

Participant Guide

FOUR MONTHS
EXTENDED MEDICAID

Objectives

☐   Participants will be able to determine how an AU becomes eligible for Four Months Extended Medicaid Because of Child Support Income (4MCS).

☐   Participants will be able to apply the non-financial requirements for 4MCS.

☐   Participants will be able to determine the eligibility period for 4MCS.

☐   Participants will be able to process changes during 4MCS on SUCCESS.

☐   Participants will be able to determine eligibility for 4MCS when a recipient reports untimely.

Outline

  I.   Introduction

  II.   Four Months Medicaid Assistance Unit (MR 2170)

  III.   Non-Financial Requirements (MR 2200)

  IV.   Financial Requirements (MR 2653 and 2715)

  V.   Qualifying Criteria for 4MCS (MR 2162 and 2170)

  VI.   Determining the First Month of 4MCS Eligibility (MR 2170)

  VII. Notification (MR 2170)

  VIII. Changes During the 4MCS Coverage Period (MR 2170)

  IX.   Continuing Medicaid Determination (MR 2170)

  X.   Katherine Norwood Walk Through/Independent Study SUCCESS Case

4 MONTHS EXTENDED MEDICAID BECAUSE OF CHILD SUPPORT (4MCS)
SUMMARY OF POINTS OF ELIGIBILITY (MR 2170)

Eligibility Requirements: AU is ineligible for LIM due to the receipt of child support. AU must have correctly received LIM in 3 of the last 6 months prior to the first month of LIM ineligibility. Eligible period is 4 months and 4MCS AU consists of all members whose needs were included in the LIM AU at the time of ineligibility.

Criterion	PROCESSING STANDARDS Summary of the Policy
Standard of Promptness (MR 2170 & 2706)	**Timely Report:** Begin 4MCS the month after timely notice expires for LIM ineligibility. **Untimely Report:** Determine when change should have been effective based on the 10 day reporting requirement (A/R has 10 days to report, Case Manager has 10 days to act, and 14 days for timely notice). Begin 4MCS the month after timely notice should have expired for LIM ineligibility if AU meets criteria. **Reviews:** Not required **Continuing Medicaid Determination:** Must be completed in the fourth month of 4MCS eligibility.

	FOUR MONTHS EXTENDED MEDICAID CRITERIA		
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
ADDR	**Residency (MR 2225)**	AU must continue to live in Georgia.	
STAT	**Living with a Specified Relative (MR 2245)**	Children must continue to be related to and living in the home of a specified relative.	Accept A/R statement.
DEM1	**Enumeration (MR 2220)**	Not required if already met under LIM.	
DEM1	**Age (MR 2255)**	Children must be under age 18.	Accept A/R statement.
DEM1	**Cooperation with Child Support Services (MR 2250)**	Not required.	
DEM2	**Citizenship/Alienage/ Identity (MR 2215)**	Each AU member must be a US citizen or lawfully admitted qualified alien. Refer to LIM policy requirements.	
DEM2	**Third Party Resources (MR 2230)**	Required at approval for 4MCS as well as during the four month coverage period.	
RES1	**Resources (MR 2301)**	Not counted.	
ERN1	**Income (MR 2170 & 2400)**	Receipt of child support income (or child support income in combination with other income, but not the other income alone) establishes ineligibility for LIM. Child support must be verified. 4MCS can continue even if child support terminates.	
ERN2	**Budgeting (MR 2170, 2653, 2655 & 2663)**	Prospective budgeting to determine LIM ineligibility due to receipt of child support income No budgeting during the four month eligibility period.	
UINC	**Application for Other Benefits (MR 2210)**	A/R must apply for and accept all monetary benefits any AU member is entitled to receive, except TANF and SSI.	Accept A/R statement.

Four Months Child Support Medicaid
(MR 2170)

Mom and children receive LIM for at least 3 months

Now receives child support which
puts the AU over the LIM income limit

AU is eligible for 4MCS

Four Months Child Support Medicaid Examples

1.   Ms. Betty Barnes and her two children, Mark and Amy, have received LIM and FS for 6 months. On 8/5 Ms. Barnes reports and verifies that her divorce from Amy's father was finalized on 8/3 and that she will begin receiving $550 child support per month for Amy in September. The Case Manager completes the case on 8/13.

   a.   Who will receive Medicaid?

   b.   When does timely notice expire?

   c.   What months will the AU receive Medicaid under 4 Months Child Support Medicaid?

Georgia Department of Human Resources
TANF BUDGET SHEET

4MCS Example #1

Name of Grantee Relative **Betty Barnes**	Number in AU **3**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **998877660**	Effective Month **September**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ ___**0**___
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ ___**500**___
(Plus deemed, less allocated income)
Gross Income Ceiling $ ___**784**___
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes ☐ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **424**

1. ☑ SON ☐ RSM Limit			
2. Earned Income			**$550.00**
			- 50.00
			$500.00
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)	**500.00**	**500.00**	
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**500.00**	**500**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Ineligible for LIM due to Child Support**		
15. Benefit Amount	**4 Months Due to Child Support Sept. – Dec.**		

Form 239 (Rev. 03/2009)

Four Months Child Support Medicaid Examples (continued)

2.   Ms. Kathy Davis has received LIM for 8 months for herself, her son, and her daughter. On 4/6 Ms. Davis reports and verifies that her son has begun receiving $700 child support per month. The first check was received 4/1. This is the AU's only income. The Case Manager completes the case on 4/10.

   a.   What type of Medicaid is appropriate for this change?

   b.   When does timely notice expire?

   c.   What is the potential time period for this type of Medicaid?

Georgia Department of Human Resources
TANF BUDGET SHEET

4MCS Example #2

Name of Grantee Relative **Kathy Davis**	Number in AU **3**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **776534218**	Effective Month **May**

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

A. Resource Test

Total Nonexempt Resources $ ____**0**____
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ ___**650**___
(Plus deemed, less allocated income)
Gross Income Ceiling $ ___**784**___
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes ☐ No

D. Eligibility/Payment Budget   **424**

		Subtotals	
1. ☑ SON ☐ RSM Limit			
2. Earned Income			**$700.00**
			- 50.00
			$650.00
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)	**650.00**	**650.00**	
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**650.00**	**650**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Ineligible for LIM due to Child Support**		
15. Benefit Amount	**4 Months Child Support May - August**		

Form 239 (Rev. 03/2009)

INCREASED INCOME – KATHERINE NORWOOD
WALK THROUGH

DOCUMENT THE CHANGE

Background – Ms. Norwood lives with her son Joey. The family was recently approved for Low Income Medicaid.

Ms. Norwood calls on 10/5/06 to report that Joey's father, Daniel Parker, started paying $300/month in direct child support beginning on 10/1/06.

Document, request verification and act on this change. The trainer will walk through this process.

STEP ONE

Access the case to document the change reported by Ms. Norwood. Request any needed verification and create an alert to track the due date.

STEP TWO

Once the verification is returned, update the documentation and enter the required data. Complete any required CMDs.

DOCUMENT THE CHANGE

AMEN

- Select R

- Enter the AU ID #

ADDR

- Access NARR to enter documentation

- Press PF15 to access the Letters submenu

FMEN

- Select A to generate a letter

- Enter C173 in the Letter Type field

LDTL

- Enter 404-555-5555 as the phone number

- Press PF4 to bypass warning message

LETT

- Enter 10/15/06 as the Due Date

- Indicate the Ongoing Medicaid case will be closed

- Indicate that child support income verification is requested

- Press ENTER through the letter screens to return to LDTL

LDTL

- Press PF14 to mail the letter

FMEN

- Select D to view the letter

- Press ENTER

LSUM

- Enter Y in the Select field to view the letter

- Press PF3 to return to ADDR

ADDR

- Access NARR to update documentation

- Fastpath to DONE

ERRO

- Address any unresolved errors

DONE

- Commit to database

AMEN

- Press PF3 to return to the Main Menu

MAIN MENU

- Select D

- Press ENTER

DMEN

- Select A

- Delete AU ID #

- Press ENTER

ALWG

- Enter your caseload ID number

- Enter Katherine Norwood's AU ID number XXXX00184

- Enter an alert code between 450 – 489

- Enter message text as follows:
  "Verification of child support income due
  Katherine Norwood"

- Enter 10/05/06 as the display date

- Enter 10/15/06 as the due date

- Press ENTER

INCREASED INCOME – KATHERINE NORWOOD INDEPENDENT STUDY

PROCESS THE CHANGE

Background – Ms. Norwood reported a change in her AU's income on 10/5/06. Verification of the new income was requested with a due date of 10/15/06. Ms. Norwood returned the requested verification on 10/7/06. She provided a statement from Joey's father regarding his child support payments.

Carefully review the verification provided. Access the alerts list to enter the data and process the change.

10/6/06

To Whom It May Concern:

    I started paying $300/month in child support payments for my son Joey on 10/1/06.

    Please feel free to phone me if you have any questions. I can be reached at 404-356-4698.

Thanks,
Daniel Parker

MAIN MENU

- Select D

- Press ENTER

DMEN

- Select B

- Press ENTER

ALPR

- Press ENTER until Ms. Norwood's alert appears

- Enter R in the Select field for Ms. Norwood's alert

- Press PF15 to access AMEN

ADDR

- Access NARR to document receipt of verification

- Fastpath to UINC for Joey

UINC – JOEY NORWOOD

- Update Date Received and Amount fields

- Access REMA to enter documentation

- Fastpath to DONE

ELIG A – F09

- Case trickled to 4MCS

- If correct, confirm the data

```
CHANGE              NON-FINANCIAL ELIGIBILITY RESULTS - ELIG         ELIG    A
Month 11 06                        2001   10 05 06                       01

AU ID XXXX00184    Prog MA    Prog Type F    Med COA F09
Confirm Y

  AU     AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat     Reasons      Date      Date    Date     Date    Type  End Date
  A                   100206   100206   100106
_____

First  Last  Rel V  Mand Finl  --Stat—Rsn   Appl    Begin  Pd Thru  Penalty
Name   Name         Incl Resp    Date       Date     Date   Date   T  Date
KATHER NOR   SE OT   Y    RE   A 100206    100206   100106
JOEY   NOR   CH OT   Y    RE   A 100206    100206   100106




Message
```

CAFI A – F09

- If correct, confirm the data

```
CHANGE              CASH ASSISTANCE FINANCIAL ELIGIBILITY - CAFI      CAFI   A
Month 11 06                        4981   10 05 06
AU ID XXXX00184    Prog MA    Prog Type S    Med COA F09
                              Net Income Test (cont)
 Resources                         Standard – 30 1/3       .00
   Resources Limit          .00    Dependent Care          .00
   Total Resources          .00    Net Earned Income       .00
 Gross Income Test                 Net Unearned Income     .00
   Gross Income Limit       .00    Deemed Income           .00
   Gross Earned Income      .00    Allocated Income        .00
   Net Unearned Income      .00    Net Income              .00
   Deemed Income            .00    Grant Amount            .00
   Allocated Income         .00    Recoupment Amount       .00
 Total Gross Income         .00    Benefit Amount          .00
 Net Income Test                   Previous Benefit        .00
   Net Income Limit         .00    Spenddown Amount
   Gross Earned Income      .00    Medical Expense Amt
   Self Employ Work Exp     .00    Net Spenddown Amt
Bnft Eff Date 100206 Bnft Confirm  Y  Reasons           Budgeting Method P
Notice Type 0011          Waive Timely Notice Period     Notice Override
Review Begin Dt 10 06  Review End Dt 04 07               Strat  2

Message

  13-note
```

ERRO

- Address any unresolved errors

DONE

- Commit to the database

AMEN

- Select R

ADDR

- Fastpath to MISC

MISC

- Enter Y in COA Correct field to confirm the Medicaid Extended Start Date

```
CHANGE               AU NON-FINANCIAL MISCELLANEOUS - MISC         MISC    A
Month 11 06                      2001   10 05 06

HOH Name KATHERINE         NORWOOD                Client ID XXXX00269
AU ID XXXX00184    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
                                                               11  06    Y


----- Review ----    Auto   ------- Lump Sum Remainder ------  Delay  QMB  RSM
Compl Mand  Last  Reasgn  Amount    100 %   133 %    185 %    Rsn   Ovr  Elig
      Std   Type   Ovr                                                    Ovr

Sched Interview        QC Penalty End Date
Del     Unit Number XXXX02     Inquiry Date 10 05 06      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
 13-note 14-schd 15-lett                    20-schs      23-alau
```

ELIG – 11/06

- If correct, confirm the data

```
CHANGE              NON-FINANCIAL ELIGIBILITY RESULTS - ELIG        ELIG    A
Month 11 06                        2001   10 05 06                          01

AU ID XXXX00184     Prog MA    Prog Type F    Med COA F09
Confirm Y

  AU     AU Status   AU Stat    Appl     Begin    Pd Thru   ---Penalty---
 Stat     Reasons     Date      Date     Date      Date    Type  End Date
  A                  100206   100206   100106
 _____

First  Last  Rel V  Mand Finl   --Stat—Rsn    Appl     Begin  Pd Thru  Penalty
Name   Name         Incl Resp      Date       Date     Date   Date   T  Date
KATHER NOR   SE OT   Y    RE   A 100206     100206   100106
JOEY   NOR   CH OT   Y    RE   A 100206     100206   100106




   Message
```

CAFI – 11/06

- If correct, confirm the data

```
CHANGE            CASH ASSISTANCE FINANCIAL ELIGIBILITY - CAFI        CAFI   A
Month 11 06                        4981   10 05 06
AU ID XXXX00184    Prog MA   Prog Type S    Med COA F09
                                Net Income Test (cont)
 Resources                      Standard – 30 1/3          .00
   Resources Limit        .00   Dependent Care             .00
   Total Resources        .00   Net Earned Income          .00
 Gross Income Test              Net Unearned Income        .00
   Gross Income Limit     .00   Deemed Income              .00
   Gross Earned Income    .00   Allocated Income           .00
   Net Unearned Income    .00   Net Income                 .00
   Deemed Income          .00   Grant Amount               .00
   Allocated Income       .00   Recoupment Amount          .00
 Total Gross Income       .00   Benefit Amount             .00
 Net Income Test                Previous Benefit           .00
   Net Income Limit       .00   Spendown Amount
   Gross Earned Income    .00   Medical Expense Amt
   Self Employ Work Exp   .00   Net Spendown Amt
Bnft Eff Date 100506 Bnft Confirm  Y  Reasons          Budgeting Method P
Notice Type 0011          Waive Timely Notice Period    Notice Override
Review Begin Dt 11 06  Review End Dt 02 07              Strat  2

Message

  13-note
```

Family Medicaid

Participant Guide

RIGHT FROM THE START MEDICAID

Objectives

☐   Participants will be able to determine who is included in the RSM AU.

☐   Participants will be able to determine who is included and/or excluded for the most common RSM budget groups.

☐   Participants will be able to apply the eligibility requirement for non-financial criteria for an RSM application.

☐   Participants will be able to apply income limits and verification requirements for an RSM application.

☐   Participants will be able to identify and apply the appropriate budgeting procedures for an RSM application.

☐   Participants will be able to apply the appropriate deductions for an RSM application.

☐   Participants will be able to complete RSM budgets using appropriate budget group size, income and deductions.

☐   Participants will be able to enter basic information on SUCCESS at Intake for an RSM application.

☐   Participants will be able to add individuals to an RSM Budget Group.

Outline

RIGHT FROM THE START MEDICAID (RSM)
SUMMARY OF POINTS OF ELIGIBILITY (MR 2182 and 2184)

Eligibility Requirements: Coverage is available only for children up to age 19 only and pregnant women. Eligibility period for RSM Child is indefinite as long as the AU meets all eligibility requirements. Eligibility period for RSM PG is the month of conception through the month in which the 60th day following termination of pregnancy falls.

Criterion	Summary of the Policy	
Standards of Promptness (MR 2050, 2065, 2706)	**Initial Application:** RSM Pg case SOP is 10 calendar days beginning with the date of application. **Reviews:** RSM Pg cases do not have a formal review. However, a special review is completed the month prior to the EDD and monthly thereafter until termination of pregnancy.	**Initial Application:** RSM Child case SOP is 45 calendar days beginning with the date of application. **Reviews:** RSM Child case is reviewed every 6 months. Reviews must be completed by the last workday of the month in which it is due.
Mandatory Forms (MR 2065)	Complete the following mandatory forms when processing a Family Medicaid application: ➢ Eligibility Determination Document (EDD) or other written interview form ➢ Form 216, Declaration of Citizenship ➢ Form 5460, Notice of Privacy Practices ➢ Form DMA-285, Third Party Liability Health Insurance (if TPL/ TPR reported) ➢ Form 138, Cooperation with Child Support Services (if a referral is required)	

RIGHT FROM THE START MEDICAID CRITERIA			
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
ADDR	**Residency (MR 2225)**	Must live or intend to live in Georgia; permanent dwelling or fixed address is not required.	Accept A/R statement.
STAT	**Living with a Specified Relative (MR 2245)**	Children are not required to live in the home with a specified relative.	Accept A/R statement.
DEM1	**Enumeration (MR 2220)**	AU members must provide a SSN or proof that they have applied for a SSN (good cause may apply for failure to provide). BG members should be asked to provide a SSN, but no penalty is imposed if they fail to do so.	▪ Accept A/R statement of SSN if the number is known. ▪ Can also accept A/R statement for application for SSN in order to process the application, but verification is required in the third month following the month of approval.
DEM1	**Age (MR 2255)**	Children are eligible through month of 19th birthday. There is no age requirement for a pregnant woman.	Accept A/R statement.
DEM1	**Cooperation with Child Support Services (MR 2250)**	RSM child cases, refer unless child-only case. **This policy is not applicable in RSM pregnant women cases.**	
DEM2	**Citizenship/ Alienage/Identity (MR 2215)**	AU members must be US citizens or qualified aliens. BG members do not have to be US citizens or qualified aliens.	Third party verification of citizenship and identity is required for each AU member. DHS documents and WEB 1 VIS/CPS is required for verifying alien status. A Declaration of Citizenship/ Alien status must be obtained for all AU members.

RIGHT FROM THE START MEDICAID CRITERIA			
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
DEM2	**Third Party Resources (MR 2230)**	AU members assign rights to Third Party Resources to the Department of Community Health when an application for Medicaid is filed.	➢ Accept A/R statement as to whether anyone in the AU has insurance. ➢ If a TPR exists, Form DMA-285 must be signed and placed in the case record.
RES1	**Resources (MR 2301)**	Not counted in RSM.	
ERN1	**Earned Income Deduction (MR 2655)**	Must be employed BG member to receive the following deductions: ▪ $90 per BG member ▪ $30 & 1/3 for 4 consecutive months; then $30 only for 8 months. This deduction is rare in RSM. ▪ Dependent care not to exceed the maximums (see below).	
ERN2	**Budgeting (MR 2653)**	Prospective Budgeting is used for all cases. Prior Months use Actual income.	
CARE	**Dependent Care Deduction (MR 2655)**	AU/BG member must be employed to receive this deduction. Expense must be incurred for a child or incapacitated individual in the home. Allow the actual amount paid up to the maximums: ▪ $200 per month for each person under 2 ▪ $175 per month for each person 2 or over	Accept A/R statement of amount paid unless questionable.

	RIGHT FROM THE START MEDICAID CRITERIA		
SUCCESS Screen	**Criterion**	**Policy Summary**	**Verification Requirement**
UINC	**Child Support Deduction (MR 2655)**	Apply $50 deduction to the total amount of child support received by the AU.	
UINC	**Application for Other Benefits (MR 2210)**	In RSM Child cases, the A/R must apply for and accept all monetary benefits that any BG member is entitled to receive, except TANF and SSI. **This policy is not applicable in RSM pregnant women cases.**	Accept A/R statement. Follow up is required in the third month following the month potential eligibility is indicated; third party verification required.
UINC	**Income Limits (MR 2650)**	**RSM PgW:** countable **NET** income not to exceed 200% of the FPL. **RSM child (0-1):** countable **NET** income not to exceed 185% of the FPL. **RSM child (1-6):** countable **NET** income not to exceed 133% of the FPL. **RSM child (6-19):** countable **NET** income not to exceed 100% of the FPL.	
UINC	**Income Verification (MR 2051, 2405)**	All income must be verified by a third party source for RSM Child cases. Accept A/R statement for excluded income. Accept A/R statement for RSM PgW cases.	

ALLISON ARROYO

Background - Allison Arroyo is a married mother of one daughter, Andrea and a newborn son, Emanuel. Mrs. Arroyo receives RSM PgW, Andrea receives RSM Child and Emanuel receives Newborn Medicaid coverage. Her husband, Carlos, does not receive Medicaid.

Assistance Units

- Pregnant women
- Children under 19

SUCCESS Financial Responsibility Code – PN/RE

Budget Groups

MUST be Included:
- Unborn child of a pregnant woman in the AU
- Spouse of a pregnant woman in the AU
- Parents, including aliens, of a child in the BG

MAY be Included:
- Minor siblings or half siblings of an RSM child unless voluntarily excluded
- Other children related to an adult in the BG
- One non-parent adult relative who is caretaker and no parent is in the home
- LIM recipient
- Newborn recipient
- Adult who fails to cooperate with CSS/TPR
- Anyone failing to meet citizenship/alien requirements (except EMA)
- Anyone failing to meet enumeration (except EMA)

SUCCESS Financial Responsibility Code - RP

NEVER INCLUDE:
- SSI recipients
- Parents of a pregnant minor treated as an adult
- Boyfriend of a pregnant woman if not the father of a mutual child
- Non-related caretaker
- Pure stepparent
- Voluntarily excluded siblings/half-siblings
- Parents and their children if the parent fails to apply for the parent's potential other benefits
- Children for whom potential other benefits were not applied

SUCCESS Financial Responsibility Code – NM

```
CHANGE                   ASSISTANCE STATUS - STAT              STAT     A
Month 11 06                        8991   10 05 06                    01

 AU ID XXXX00190  Prog MA  Prog Type F  Prev ABD Type    Med COA F22   Claim N
    CO 044    LO 049    Load ID 1798    Conversion Date

  AU     AU Status   AU Stat    Appl    Begin   Pd Thru  ---Penalty----  Appeal
 Stat     Reasons     Date      Date     Date     Date   Type  End Date    Ind
  A                  100206    100206   100106
 --------------------------------------------------------------------------------
 First  Last   Rel V  Mand Finl   --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name          Incl Resp     Date         Date    Date   Date   T  Date
 ALLISO ARR    SE OT   Y    RP    A 100206       100206  100106
 CARLOS ARR    SP OT   Y    RP    A 100206       100206  100106
 ANDREA ARR    CH OT   Y    RE    A 100206       100206  100106



 Message 0013 04
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                               20-rmen      22-alau(arch)     23-alau(curr)
```

RP – Budget Group Member

RE – Assistance Unit Member

```
_____
CHANGE                    ASSISTANCE STATUS - STAT              STAT    B
Month 11 06                      8991   10 05 06                     01

 AU ID XXXX00191  Prog MA  Prog Type   Prev ABD Type    Med COA P01   Claim N
   CO 044    LO 049    Load ID 1798    Conversion Date

  AU    AU Status  AU Stat    Appl    Begin    Pd Thru  ---Penalty----  Appeal
 Stat    Reasons     Date     Date     Date     Date    Type  End Date   Ind
  A                 100206   100206   100106
 ------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl   --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp      Date         Date    Date   Date   T  Date
 ALLISO ARR    SE OT   Y    RE    A 100206      100206  100106
 CARLOS ARR    SP OT   Y    RP    A 100206      100206  100106
 ANDREA ARR    CH OT   Y    RP    A 100206      100206  100106



 Message 0013 04
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                              20-rmen      22-alau(arch)     23-alau(curr)
_____
```

RE – Assistance Unit Member

RP – Budget Group Member

THE MOST COMMON BUDGET GROUP SITUATIONS

1.   Pregnant Woman Lives Alone

The budget group would include the woman and the unborn child; so this would be a Budget Group of 2. If the woman provides medical evidence to substantiate that there is more than one unborn child (twins for example), the budget group would be increased accordingly. A woman pregnant with twins would be a Budget Group of 3.

2.   Pregnant Woman Lives With Her Other Children

The pregnant woman, the unborn, and each child would normally be included in the Budget Group. If, however, you need to exclude one of the children (because s/he has income that is excessive) you may do so. If you do exclude a child from a budget group, you may consider eligibility for that child in a separate AU/BG of the same or different COA.

3.   Mom, Dad, and Their Child

The Budget Group would include the Mother, Father and the child.

4. Mom, Her Child, and Her Niece

One possibility: Mom, her child, and the niece all in one Budget Group.

Second possibility: Mom and her child in one group and niece in a group by herself.

Choose the one that is best for the family.

5. Pregnant Woman Lives With Her Boyfriend and the Unborn is His Child

The Budget Group consists of the woman and the unborn. The boyfriend is NOT in the budget group.

6. Pregnant Woman Lives with Her Husband

The Budget Group consists of the woman, the unborn and the husband.

7.   **Pregnant Minor Lives with Her Mother and Siblings**

First possibility: Put everyone in the same Budget Group together, count the minor as a child (so the unborn doesn't count).

Second possibility: Do a Budget Group for the minor and the unborn and forget about everyone else.

Third possibility: Do two separate groups with the minor and unborn in one and the mother and siblings in another.

EXAMPLES: RSM AU/BG

1. Ms. Morris (pregnant) applies for herself.

   BG = 2 (Ms. Morris and unborn);
   AU = 1 (Ms. Morris)

2. Ms. Palmer (pregnant) applies for herself and her 3-year-old son. They are not eligible for LIM.

   BG = 3 (Ms. Palmer, son, unborn)
   AU = 2 (Ms. Palmer and her son)

3. Ms. Sams (pregnant) applies for herself. She is pregnant with twins.

   BG = 3 (Ms. Sams & two unborn)
   AU = 1 (Ms. Sams)

4. Ms. Rogers (pregnant) applies for herself and her 2 year old. They are not eligible for LIM.

   BG = 3 (Ms. Rogers, unborn, and child)
   AU = 2 (Ms. Rogers and child)

5. Ms. Brown applies for her four-year-old son and her twelve year-old son. They are not eligible for LIM.

   BG = 3 (Ms. Brown, 12- year-old and 4- year-old)
   AU = 2 (12- year-old and 4- year- old)

   If financially ineligible as a BG of 3, Ms. Brown may apply for each child separately.

   BG = 2 (Ms. Brown and 12- year-old)   BG = 2 (Ms. Brown and 4- year-old)
   AU = 1 (12- year-old)   AU = 1 (4- year old)

6.   Ms. Kent applies for her son (4) and her nephew (10).

      Possible BG = 3 (Ms. Kent, son and nephew)

      OR

      Possible 2 BGs:

      BG #1 = 2   BG #2 = 1
      (Ms. Kent and son)   (nephew)

7.   Ms. Lane applies for her niece (8). Also in the home are Ms. Lane's husband and their son (6).

      Possible BG = 1 (niece)   Possible BG = 2 (Ms. Lane and niece)
       AU = 1 (niece)   AU = 1 (niece)
                              OR
      If Ms. Lane wants Medicaid for her son or needs to increase the limit:
      BG = 4 (Ms. Lane, niece, son, Mr. Lane)
      AU = 2 (niece and son)

8.   Ms. Jones receives SSI and applies for her son (5).

      BG = 1 (child)
      AU = 1 (child)

9.   Ms. Finn is 15 and pregnant.
      She lives with her parents and
      applies for herself.

      BG = 2 (Ms. Finn and unborn)
      AU = 1 (Ms. Finn)

10.   Ms. Blue is 15 and pregnant. She lives with her parents and two
      younger sisters. Her mother applies for all 3 of the girls.

      BG = 5 (both parents, 3 girls)
      AU = 3 (3 girls)

11. Ms. Green, pregnant, applies for herself. She lives with Mr. Tucker, who is the father of the unborn child.   No one else lives with them.

   BG = 2 (Ms. Green and unborn)
   AU = 1 (Ms. Green)

12. Ms. Smith, pregnant, applies for herself. She also lives with her husband, Jack, who is the father of her unborn child.

   RSM-PG-W BG = 3 (Ms. Smith, Mr. Smith, and unborn)
   AU = 1 (Ms. Smith)

RSM EXAMPLES

RSM Pregnant Women Medicaid (RSM-PgW)

1. Ms. Mona Kirk is pregnant and lives alone. She earns $1800 gross per month.
    Ms. Kirk has never received Medicaid. She applies for Medicaid on May 4 and has
    an unpaid medical bill for April. Ms. Kirk's EDD is December 15. All eligibility
    requirements are met and the case is completed on May 8.

    Who is eligible for Medicaid?

    What is the time period for this type of Medicaid?

2. Ms. Vickie Elliot is pregnant and lives with her husband Mike. Her EDD is July 21.
    Mr. Elliot earns $2195 gross per month and Ms. Elliot has zero income. The family
    has never received Medicaid. They apply for Medicaid on November 2. All
    eligibility requirements are met and the case is completed on November 6.

    Who is eligible for Medicaid?

    What is the time period for this type of Medicaid?

Georgia Department of Human Resources

TANF BUDGET SHEET

RSM EXAMPLE #1

Name of Grantee Relative **Mona Kirk**	Number in AU/**BG** **2**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change

AU ID Number **115827431**	Effective Month **April/Ongoing**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? ☐ Yes   ☐ No

Gross Wages $_____
Less Standard Deduction $90 $_____
Less Child Care $_____ $_____
Plus Unearned Income $_____ $_____
Plus Deemed Income $_____ $_____
Less Allocation $_____ $_____
Total $_____
SON $_____
Surplus/Deficit $_____
Eligible for $30 + 1/3?   ☐ Yes   ☐ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes   ☐ No

D. Eligibility/Payment Budget   **2429**

1. ☐ SON ☑ RSM Limit			
2. Earned Income/**Wages**	**1800.00**		
Total Earned Income	**1800.00**	**Subtotals**	
3. Less $90	**90.00**	**1710.00**	
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**1710.00**	**1710**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Eligible for RSM PgW**		
15. Benefit Amount			

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

RSM EXAMPLE #2

Name of Grantee Relative **Vickie Elliot**	Number in AU/**BG** **3**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change

AU ID Number **276433985**	Effective Month **November/Ongoing**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? □ Yes   □ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? □ Yes   □ No

C. Standard of Need Test

Gross Wages		$ _____
Less Standard Deduction	$90	$ _____
Less Child Care	$ _____	$ _____
Plus Unearned Income	$ _____	$ _____
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ _____
SON		$ _____
Surplus/Deficit		$ _____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   **3052**

1. □ SON ☑ RSM Limit				
2. Earned Income/**Mr. Elliot**	**2195.00**			
Total Earned Income	**2195.00**	**Subtotals**		
3. Less $90	**90.00**	**2105.00**		
4. Less $30				
5. Less 1/3				
6. Less Child Care				
7. Net Earned Income				
8. Plus Unearned Income				
9. Plus Child Support (Less $50 – Medicaid only)				
10. Plus Deemed Income				
11. Less Allocation				
12. Total Countable Income			**2105.00**	**2105**
13. Surplus/Deficit (SON less line 12)				
14. Family Maximum	**Eligible for RSM PgW**			
15. Benefit Amount				

Form 239 (Rev. 03/2009)

RSM Child Medicaid

3. Jimmy Fisher (2) lives with both of his parents. His mother stays at home to care
    for him. His father earns $1479 gross per month. There is no $30 and 1/3. They
    apply for Medicaid on March 2. All eligibility requirements are met and the case is
    completed on March 26.

    Who is eligible for Medicaid?

    What is the time period for this type of Medicaid?

4. Ms. Elissa Mason lives with her 14-year-old son David. While David is in school,
    Ms. Mason works earning $890 gross per month. There is no $30 and 1/3. Ms.
    Mason has a savings account with a balance of $300. They
    apply for Medicaid on January 12. All eligibility requirements are
    met and the case is completed on January 30.

    Who is eligible for Medicaid?

    What is the time period for this type of Medicaid?

5. Mary and James Smith apply for assistance for their 10-month old son, Joe. Ms.
    Smith works earning $2060 gross per month. There is no $30 and 1/3. They apply
    for Medicaid on October 9. All eligibility requirements are met and the case is
    completed on November 10.

    Who is eligible for Medicaid?

    What is the time period for this type of Medicaid?

Georgia Department of Human Resources
TANF BUDGET SHEET

RSM EXAMPLE #3

Name of Grantee Relative **Mrs. Fisher**	Number in AU **3**	Action Taken: □ Trial ☑ Initial □ Review □ Change

AU ID Number **337258944**	Effective Month **March/Ongoing**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ __0__
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ __1479__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __784__
Surplus/Deficit $ _____
Eligible based on GIC test? □ Yes   ☑ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   **Ineligible for LIM**

1. □ SON □ RSM Limit		
2. Earned Income		
Total Earned Income		**Subtotals**
3. Less $90		
4. Less $30		
5. Less 1/3		
6. Less Child Care		
7. Net Earned Income		
8. Plus Unearned Income		
9. Plus Child Support (Less $50 – Medicaid only)		
10. Plus Deemed Income		
11. Less Allocation		
12. Total Countable Income		
13. Surplus/Deficit (SON less line 12)		
14. Family Maximum		
15. Benefit Amount		

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

RSM EXAMPLE #3

Name of Grantee Relative **Mrs. Fisher**	Number in AU/**BG** **3**	Action Taken: □ Trial ☑ Initial □ Review □ Change

AU ID Number **337258944**	Effective Month **March/Ongoing**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? □ Yes   □ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? □ Yes   □ No

C. Standard of Need Test

Gross Wages		$ _____
Less Standard Deduction	$90	$ _____
Less Child Care	$ _____	$ _____
Plus Unearned Income	$ _____	$ _____
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ _____
SON		$ _____
Surplus/Deficit		$ _____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget **2030**

1. □ SON ☑ RSM Limit				
2. Earned Income **Mr. Fisher**	**1479.00**			
Total Earned Income	**1479.00**	**Subtotals**		
3. Less $90	**90.00**	**1389.00**		
4. Less $30				
5. Less 1/3				
6. Less Child Care				
7. Net Earned Income		**1389.00**		
8. Plus Unearned Income				
9. Plus Child Support (Less $50 – Medicaid only)				
10. Plus Deemed Income				
11. Less Allocation				
12. Total Countable Income		**1389.00**	**1389**	
13. Surplus/Deficit (SON less line 12)				
14. Family Maximum	**Eligible RSM Child (1-5)**			
15. Benefit Amount	**Jimmy**			

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Georgia Department of Human Resources
TANF BUDGET SHEET

RSM EXAMPLE #4

Name of Grantee Relative **Elissa Mason**	Number in AU **2**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change

| AU ID Number
101110112 | Effective Month
January/Ongoing | **C. Standard of Need Test** |

A. Resource Test

Total Nonexempt Resources $ ___**300**___
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ ___**890**___
(Plus deemed, less allocated income)

Gross Income Ceiling $ ___**659**___
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes   ☑ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **Ineligible for LIM**

1. ☐ SON ☐ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

RSM EXAMPLE #4

Name of Grantee Relative **Elissa Mason**	Number in AU**/BG** **2**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change

AU ID Number **101110112**	Effective Month **January/Ongoing**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? □ Yes   □ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? □ Yes   □ No

C. Standard of Need Test

Gross Wages		$ _____
Less Standard Deduction	$90	$ _____
Less Child Care	$ _____	$ _____
Plus Unearned Income	$ _____	$ _____
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ _____
SON		$ _____
Surplus/Deficit		$ _____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   **1215**

			Subtotals	
1. □ SON ☑ RSM Limit				
2. Earned Income **Mr. Fisher**	890.00			
Total Earned Income	890.00	**Subtotals**		
3. Less $90	90.00	800.00		
4. Less $30				
5. Less 1/3				
6. Less Child Care				
7. Net Earned Income		800.00		
8. Plus Unearned Income				
9. Plus Child Support (Less $50 – Medicaid only)				
10. Plus Deemed Income				
11. Less Allocation				
12. Total Countable Income		800.00	800	
13. Surplus/Deficit (SON less line 12)				
14. Family Maximum	**Eligible RSM Child (6-19)**			
15. Benefit Amount	**David**			

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

RSM EXAMPLE #5

Name of Grantee Relative **Mrs. Smith**	Number in AU **3**

Action Taken: □ Trial   ☑ Initial
□ Review   □ Change

AU ID Number **558473932**	Effective Month **Oct/Nov/Dec**

A. Resource Test

Total Nonexempt Resources $ **0**
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ **2060**
(Plus deemed, less allocated income)
Gross Income Ceiling $ **784**
Surplus/Deficit $ _____
Eligible based on GIC test? □ Yes   ☑ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   **Ineligible for LIM**

1. □ SON □ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

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Georgia Department of Human Resources
TANF BUDGET SHEET

RSM EXAMPLE #5

Name of Grantee Relative **Mrs. Smith**	Number in AU/**BG** **3**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change
AU ID Number **558473932**	Effective Month **Oct/Nov/Dec**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? ☐ Yes   ☐ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes   ☐ No

C. Standard of Need Test		
Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **2823**

1. ☐ SON ☑ RSM Limit				
2. Earned Income **Mr. Smith**	2060.00			
Total Earned Income	2060.00	**Subtotals**		
3. Less $90	90.00	1970.00		
4. Less $30				
5. Less 1/3				
6. Less Child Care				
7. Net Earned Income		1970.00		
8. Plus Unearned Income				
9. Plus Child Support (Less $50 – Medicaid only)				
10. Plus Deemed Income				
11. Less Allocation				
12. Total Countable Income		1970.00	1970	
13. Surplus/Deficit (SON less line 12)				
14. Family Maximum	**Eligible RSM Child (0-1)**			
15. Benefit Amount	**Joe**			

Form 239 (Rev. 03/2009)

Combination RSM PgW and RSM Child

6. Ms. Wanda Jones applies for assistance for her son Mark (7) and herself. She is pregnant with an EDD of September 1. Ms. Jones earns $1100 gross per month. There is no $30 and 1/3, but she pays $250/month child care. They apply for Medicaid on February 27. All eligibility requirements are met and the case is completed on March 6.

Who is eligible for Medicaid?

What is the time period for this type of Medicaid?

<div align="center">

GEORGIA DEPARTMENT OF HUMAN RESOURCES
TANF BUDGET SHEET

RSM EXAMPLE #6

</div>

Name of Grantee Relative **Wanda Jones**	Number in AU **2**	Action Taken: □ Trial ☑ Initial □ Review □ Change
AU ID Number **107101240**	Effective Month **Feb/Mar/April**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ ____**0**____
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test
Gross Income $ __**1100**__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __**659**__
Surplus/Deficit $ _____
Eligible based on GIC test? □ Yes   ☑ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   Ineligible for LIM

1. □ SON □ RSM Limit		
2. Earned Income		
Total Earned Income		**Subtotals**
3. Less $90		
4. Less $30		
5. Less 1/3		
6. Less Child Care		
7. Net Earned Income		
8. Plus Unearned Income		
9. Plus Child Support (Less $50 – Medicaid only)		
10. Plus Deemed Income		
11. Less Allocation		
12. Total Countable Income		
13. Surplus/Deficit (SON less line 12)		
14. Family Maximum		
15.Benefit Amount		

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

RSM EXAMPLE #6

Name of Grantee Relative **Wanda Jones**	Number in AU**/BG** **3**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change

AU ID Number **107101240**	Effective Month **Feb/Mar/April**

C. Standard of Need Test

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? ☐ Yes   ☐ No

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes   ☐ No

D. Eligibility/Payment Budget

1526 / 3052

1. ☐ SON ☑ RSM Limit			
2. Earned Income **Ms. Jones**	1100.00		
Total Earned Income	1100.00	**Subtotals**	
3. Less $90	90.00	1010.00	
4. Less $30			
5. Less 1/3			
6. Less Child Care	175.00	835.00	
7. Net Earned Income		835.00	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		835.00	835
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**Eligible RSM Child (6-19) Mark**		
15. Benefit Amount	**Eligible RSM PgW Ms. Jones**		

Form 239 (Rev. 03/2009)

RSM APPLICATION – JUDY COLLINS
WALK THROUGH

Background – The AU consists of Judy Collins and her two year old son, Kyle. Ms. Collins is pregnant and does not have health insurance available where she works. She has also requested prior months Medicaid for herself. Ms. Collins applies for Medicaid for herself and her son. The applications have been registered by clerical support staff.

Review her Form 94 prior to beginning your eligibility determination.

While in your office on October 2nd, Ms. Collins provides all verification.

Process her applications while she is in your office on October 2nd.

INTERVIEW

AMEN

- Select O to begin the interview process

- Enter the P01 AU ID #

```
              ASSISTANCE UNIT/CLIENT SUBMENU - AMEN              AMEN

                        Selection O
              AU ID XXXX00186              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
```

ADDR

- Information from Registration is pre-populated

- Residential County Code is 044

- Delete extra digit in zip code field

- Access NARR to enter documentation

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

CO 044  LO 049  Load ID 1020  Client ID 02000XXXX  RES CO 044
HOH F Name JUDY          MI     L Name COLLINS              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
        105         ABERCORN             ST
City SAVANNAH            ST GA   Zip 31401    0   Phone 912 555 9898

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 2132     2133
2132 CORRECT STREET NUMBER OR EMTER RES CO FIELD
     15-lett                         21-narr  23-alau  24-del
```

STAT A – P01

- Relationship is verified by AR's statement

- All individuals are mandatory to be included

- Enter PN in the Financial Responsibility field for Ms. Collins as she is an AU member

- Enter RP in the Financial Responsibility field for Kyle as he is a BG member

- Access ADT to enter documentation

- There are no other household members

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

 AU ID XXXX00186  Prog MA  Prog Type P  Prev ABD Type    Med COA P01   Claim N
    CO 044    LO 049    Load ID XXXX    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
 JUDY   COL   SE OT   Y    PN   P 100206      100206
 KYLE   COL   CH OT   Y    RP   P 100206      100206



 Message

                           20-rmen      22-alau(arch)     23-alau(curr)
```

STAT B – F22

- Relationship is verified by AR's statement

- All individuals are mandatory to be included

- Enter RP in the Financial Responsibility field for Ms. Collins as she is a BG member

- Enter PN in the Financial Responsibility field for Kyle as he is an AU member

- Access ADT to enter documentation

- There are no other household members

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

AU ID XXXX00187  Prog MA  Prog Type P  Prev ABD Type    Med COA F22   Claim N
   CO 044    LO 049    Load ID XXXX    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
JUDY   COL   SE OT  Y    RP   P 100206        100206
KYLE   COL   CH OT  Y    PN   P 100206        100206




  Message
             20-rmen      22-alau(arch)      23-alau(curr)
```

DEM1 – Judy Collins

- Legally separated from her husband since 5/06

- Lives at home

- Does not receive SSI

- EDD is 3/12/07; verified by her doctor

- Expecting one child; verified by her doctor

- Access REMA to enter documentation

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

 Client Name JUDY          COLLINS              Suf      Client ID 02000XXXX

 Alt   SSA/SSN   SSN Appl     SSN1    V   More         DOB      V Sex Race Eth
 Name  Appl For   Date                   SSNs    (MM DD YYYY)
                            114 11 XXXX  CS          05 28 1980   CS  F   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     S          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                              D      03 12 07  DO  1  DO


 Message
```

DEM2 – Judy Collins

- U.S. Citizen; verified by birth certificate

- Agrees to cooperate with TPL requirements

- Access ADT to enter documentation

- Identity verified by GA driver's license

DEM1 – Kyle Collins

- Lives at home

- Does not receive SSI

- Access REMA to enter documentation

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

  Client Name KYLE          COLLINS              Suf      Client ID 02000XXXX

  Alt    SSA/SSN   SSN Appl    SSN1    V   More        DOB      V Sex Race Eth
  Name  Appl For    Date                   SSNs    (MM DD YYYY)
                             114 12 XXXX  CS           12 31 2004  CS  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      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
```

DEM2 – Kyle Collins

- U.S. Citizen; verified by birth certificate

- Health Check referral made on 10/5/06

- Access ADT to enter documentation

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

 Client Name KYLE            COLLINS              Client ID 02000XXXX

 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                                  Y   10 05 06

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


 Non-Custodial Parent?     V

  Message 0013
```

*Please note that though resources are not counted in RSM, it is good case management to document information provided by the AU.

RES1 – Judy Collins

- Checking account at Memorial Credit Union with a balance of $15

RES2 – Judy Collins

- Owns a 1997 Chevrolet Camaro valued at $1500; verified by NADA

- Used for employment

- Owes $700; verified by her statement

ERN1 – Judy Collins

- Employed as an LPN by Azalealand Nursing Home located at 2040 Colonial Drive, Savannah, GA 31406

- Phone number is 912-555-2752

- Began employment on 8/27/06; received first pay on 9/4/06

- Access ADT to enter documentation

- Clearinghouse screens viewed; no discrepancies noted

ERN2 – Judy Collins

- Earned income fluctuates each pay period

- Press PF16 to access EVNC

EVNC – Judy Collins

- Works an average of 26 hours per pay period

- Paid weekly on Fridays

- Enter all earned income; verified by check stubs

- Check dated 9/25/06 is not representative

- Ms. Collins missed work the week of 9/25/06 because Kyle was sick

```
INTERVIEW            EARNED VARIABLE INCOME CALCULATION - EVNC        EVNC 01
 Month 11 06

  Client Name JUDY          COLLINS              Client ID XXXX00276
 Del      Avg Hours 26     Freq WK    Day Week Pd FR     Extra Pay

      PP End Date    Pd/Rcvd Date    Amount        V          Repres
      MM DD YY
      08 30 06        09 04 06       193.05        CH          Y
      09 06 06        09 11 06       198.90        CH          Y
      09 13 06        09 18 06       198.90        CH          Y
      09 20 06        09 25 06        99.45        CH          N





 Message
  24-del
```

ERN2 – Judy Collins

- Ensure data is correct

- Access EVNC ADT to enter documentation

- Check dated 9/25 was not representative because Kyle was sick

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

 Client Name JUDY          COLLINS           Client ID XXXX00276

 Employer AZALEALAND NURSING HOME INC.

             Avg Hrs 026   Freq WK   Day Week Pd FR   Extra Pay

 Del

  Amt 1    V    Amt 2    V    Amt 3    V    Amt 4    V     Extra    V
  196.95   VN
 ------------------------ Work Expenses --------------------------
        Type  Amount  Freq V       Type  Amount  Freq V


                                                    More Jobs
  Message

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

```
UPDATE                        REMARKS - REMA                    REMA
                                                                  01
   ******************************* ERN2 EVNC *******************************
   10/05/2006 12:31 PM Family Medicaid Training 555-555-5555
   App(X)  Review( )  Hourly Rate:__$7.50_____

   Client states the pay periods listed on EVNC are representative of
   expected pay with the following exceptions:_Check received 9/25 is not_
   :representative because A/R missed work due to child's illness._____
   :_____
   Does AU member receive tips that are not included in the gross pay?

   Y/N (N)    If yes, explain:_____
   :_____
   :

                                                                  More
   MESSAGE

   13-bott
```

CARE – Judy Collins

- Childcare is provided by Ms. Collins's mother, Linda Hall

- Ms. Hall does not charge Ms. Collins for taking care of Kyle

- Ms. Hall resides at 463 Lakeview Terrace

- Her phone number is 912-555-5412

- Access REMA to enter documentation

UINC – Judy Collins

- Access REMA to enter documentation

MISC A – P01

- No data to enter

MISC B – F22

- Next review is an alternate

DONE

- Commit to the database

PROCESS

AMEN

- Select P

APP1

- Select benefit month 10/06

ADDR

- Fastpath to DONE

DONE

- Commit to the database

APP1

- Return to AMEN

FINALIZE P01

AMEN

- Select Q

- Enter P01 AU ID #

APP2

- Press ENTER

ELIG – 10/06

- If correct, confirm the data

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

 AU ID XXXX00186     Prog MA     Prog Type P    Med COA P01
 Confirm Y

  AU      AU Status   AU Stat    Appl     Begin    Pd Thru   ---Penalty---
  Stat     Reasons     Date      Date     Date      Date     Type End Date
  A                   100506   100206   100106   103106
 --------------------------------------------------------------------------------
 First   Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin   Pd Thru  Penalty
 Name    Name         Incl Resp     Date        Date    Date    Date    T  Date
 JUDY    COL   SE OT   Y    RE   A 100506        100206  100106 103106
 KYLE    COL   CH OT   Y    RP   A 100506        100206  100106 103106




 Message
```

CAFI – 10/06

- If correct, confirm the data

```
FINALIZE              CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
  Month 10 06
 AU ID XXXX00186   Prog MA   Prog Type F      Med COA  P01
                                  Net Income Test (cont)
 Resources                          Standard - 30 1/3      90.00
   Resource Limit           .00   Dependent Care            .00
   Total Resources          .00   Net Earned Income      763.44
 Gross Income Test                 Net Unearned Income       .00
   Gross Income Limit       .00   Deemed Income             .00
   Gross Earned Income    853.44  Allocated Income          .00
   Net Unearned Income      .00   Net Income             763.00
   Deemed Income            .00   Grant Amount              .00
   Allocated Income         .00   Recoupment Amount         .00
 Total Gross Income       853.44  Benefit Amount            .00
 Net Income Test                   Previous Benefit         .00
   Net Income Limit      2768.00  Spenddown Amount
   Gross Earned Income    853.44  Medical Expense Amt
   Self Employ Work Exp     .00   Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm  Y   Reasons            Budgeting Method P
 Notice Type 0003          Waive Timely Ntc Period    Notice Override
  Review Begin Date 10 06   Review End Date 99 99          Strat 2
 Message
```

ELIG – 11/06

- If correct, confirm the data

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

  AU ID XXXX00186     Prog MA    Prog Type P    Med COA P01
  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
 JUDY   COL   SE OT  Y    RE   A 100506        100206  110106
 KYLE   COL   CH OT  Y    RP   A 100506        100206  110106




  Message
```

CAFI – 11/06

- If correct, confirm the data

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI           CAFI    A
  Month 11 06
AU ID XXXX00186   Prog MA   Prog Type F      Med COA  P01
                             Net Income Test (cont)
 Resources                       Standard - 30 1/3     90.00
   Resource Limit          .00   Dependent Care           .00
   Total Resources         .00   Net Earned Income     763.44
 Gross Income Test               Net Unearned Income      .00
   Gross Income Limit      .00   Deemed Income            .00
   Gross Earned Income  853.44   Allocated Income         .00
   Net Unearned Income     .00   Net Income            763.00
   Deemed Income           .00   Grant Amount             .00
   Allocated Income        .00   Recoupment Amount        .00
 Total Gross Income     853.44   Benefit Amount           .00
 Net Income Test                 Previous Benefit         .00
   Net Income Limit    2768.00   Spenddown Amount
   Gross Earned Income  853.44   Medical Expense Amt
   Self Employ Work Exp    .00   Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm  Y  Reasons          Budgeting Method P
 Notice Type 0003        Waive Timely Ntc Period        Notice Override
  Review Begin Date 10 06   Review End Date 99 99         Strat 2
 Message
```

APP2

- Finalize the P01 application

FINALIZE F22

AMEN

- Select Q

- Enter the F22 AU ID #

APP2

- Press ENTER

ELIG – 10/06

- If correct, confirm the data

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

 AU ID XXXX00187     Prog MA     Prog Type F     Med COA F22
 Confirm Y

  AU      AU Status   AU Stat     Appl     Begin    Pd Thru   ---Penalty---
  Stat     Reasons     Date       Date      Date     Date    Type  End Date
  A                    100506    100206    100106
 --------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl   --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp     Date          Date    Date   Date   T  Date
 JUDY   COL   SE OT   Y     RP   A 100506        100206 100106
 KYLE   COL   CH OT   Y     RE   A 100506        100206 100106




 Message
```

CAFI – 10/06

- If correct, confirm the data

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
  Month 10 06
 AU ID XXXX00187   Prog MA   Prog Type F       Med COA  F22
                              Net Income Test (cont)
 Resources                       Standard - 30 1/3      90.00
   Resource Limit         .00  Dependent Care           .00
   Total Resources        .00  Net Earned Income     763.44
 Gross Income Test             Net Unearned Income      .00
   Gross Income Limit     .00  Deemed Income            .00
   Gross Earned Income  853.44 Allocated Income         .00
   Net Unearned Income    .00  Net Income            763.00
   Deemed Income          .00  Grant Amount             .00
   Allocated Income       .00  Recoupment Amount        .00
 Total Gross Income     853.44 Benefit Amount           .00
 Net Income Test               Previous Benefit         .00
   Net Income Limit    1840.00 Spenddown Amount
   Gross Earned Income  853.44 Medical Expense Amt
   Self Employ Work Exp   .00  Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm  Y Reasons          Budgeting Method P
 Notice Type 0003       Waive Timely Ntc Period         Notice Override
  Review Begin Date 10 06   Review End Date 04 07         Strat 2
 Message
```

ELIG – 11/06

- If correct, confirm the data

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

  AU ID XXXX00187    Prog MA    Prog Type F   Med COA F22
  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
  JUDY   COL   SE OT   Y    RP   A 100506        100206 110106
  KYLE   COL   CH OT   Y    RE   A 100506        100206 110106




  Message
```

CAFI – 11/06

- If correct, confirm the data

```
FINALIZE              CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
  Month 11 06
AU ID XXXX00187   Prog MA   Prog Type F      Med COA  F22
                              Net Income Test (cont)
 Resources                         Standard - 30 1/3      90.00
   Resource Limit            .00   Dependent Care            .00
   Total Resources           .00   Net Earned Income      763.44
 Gross Income Test                 Net Unearned Income       .00
   Gross Income Limit        .00   Deemed Income             .00
   Gross Earned Income    853.44   Allocated Income          .00
   Net Unearned Income       .00   Net Income             763.00
   Deemed Income             .00   Grant Amount              .00
   Allocated Income          .00   Recoupment Amount         .00
 Total Gross Income       853.44   Benefit Amount            .00
 Net Income Test                   Previous Benefit          .00
   Net Income Limit      1840.00   Spenddown Amount
   Gross Earned Income    853.44   Medical Expense Amt
   Self Employ Work Exp      .00   Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm  Y  Reasons            Budgeting Method P
 Notice Type 0003          Waive Timely Ntc Period          Notice Override
  Review Begin Date 10 06    Review End Date 04 07           Strat 2
 Message
 13-note
```

APP2

- Finalize the F22 application

PRIOR MONTHS – JUDY COLLINS
WALK THROUGH

Background – Ms. Collins requests Medicaid for prior months for herself. Her son has no unpaid medical bills. Verification of earned income for the appropriate months is provided. She states she had no resources prior to filing her application for Medicaid.

Refer to Ms. Collins's Form 94 to identify the appropriate months for which coverage is requested and available.

STEP ONE - 5

AMEN

- Select 5

- Enter the P01 AU ID #

PMCO

- Select the appropriate months

STEP TWO - R

AMEN

- Select R

- Benefit Month is 08/06

ADDR

- Access NARR to enter documentation

- Fastpath to RES1 for Judy Collins

RES1

- Delete all resources

- Fastpath to ERN1 for Judy Collins

ERN1

- Note that Ms. Collins began her employment in August 2006, but did not receive her first check until September 2006

ERN2

- Delete employer information

- Fastpath to DONE

DONE

- Commit to the database

AMEN

- Select R

- Benefit Month is 09/06

ADDR

- Fastpath to RES1 for Judy Collins

RES1

- Delete all resources

- Fastpath to ERN2 for Judy Collins

ERN2

- Access EVNC

EVNC

- Press END to delete the data from each field

- Press ENTER

ERN2

- Enter actual income earned in 9/06

- Access ADT to enter documentation

STEP THREE - 6

AMEN

- Select 6

FPME

- Press ENTER

ELIG – 08/06

- If correct, confirm the data

```
FINALIZE            NON-FINANCIAL ELIGIBILITY RESULTS - ELIG        ELIG    A
Month 08 06                                                          01

 AU ID XXXX00186    Prog MA    Prog Type P    Med COA P01
 Confirm Y

  AU     AU Status   AU Stat    Appl    Begin     Pd Thru   ---Penalty---
  Stat     Reasons    Date      Date     Date      Date    Type  End Date
  A                  100506    100206   080106    083106
 ---------------------------------------------------------------------------
 First   Last  Rel V  Mand Finl  --Stat-- Rsn  Appl    Begin  Pd Thru  Penalty
 Name    Name         Incl Resp    Date         Date    Date   Date    T  Date
 JUDY    COL   SE OT   Y    RE   A 100506        100206  080106 083106
 KYLE    COL   CH OT   Y    RP   A 100506        100206  080106 083106




 Message
```

CAFI – 08/06

- If correct, confirm the data

```
FINALIZE              CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
  Month 08 06
AU ID XXXX00186   Prog MA   Prog Type P      Med COA  P01
                              Net Income Test (cont)
Resources                        Standard - 30 1/3        .00
  Resource Limit          .00   Dependent Care            .00
  Total Resources         .00   Net Earned Income         .00
Gross Income Test               Net Unearned Income       .00
  Gross Income Limit      .00   Deemed Income             .00
  Gross Earned Income     .00   Allocated Income          .00
  Net Unearned Income     .00   Net Income                .00
  Deemed Income           .00   Grant Amount              .00
  Allocated Income        .00   Recoupment Amount         .00
Total Gross Income        .00   Benefit Amount            .00
Net Income Test                 Previous Benefit          .00
  Net Income Limit     2768.00  Spenddown Amount
  Gross Earned Income     .00   Medical Expense Amt
  Self Employ Work Exp    .00   Net Spenddown Amt
Bnft Eff Date 100506  Bnft Confirm  Y   Reasons           Budgeting Method P
Notice Type 0004          Waive Timely Ntc Period     Notice Override
 Review Begin Date 10 06    Review End Date 99 99         Strat
Message

 13-note
```

ELIG – 09/06

- If correct, confirm the data

```
FINALIZE            NON-FINANCIAL ELIGIBILITY RESULTS - ELIG        ELIG    A
Month 09 06                                                         01

 AU ID XXXX00186     Prog MA    Prog Type P   Med COA P01
 Confirm  Y

  AU    AU Status   AU Stat   Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons     Date     Date    Date     Date     Type  End Date
  A                 100506   100206  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
 JUDY   COL   SE OT   Y    RE   A 100506      100206 090106 093006
 KYLE   COL   CH OT   Y    RP   A 100506      100206 090106 093006




 Message
```

CAFI – 09/06

- If correct, confirm the data

```
FINALIZE              CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
  Month 09 06
 AU ID XXXX00186   Prog MA   Prog Type P      Med COA  P01
                              Net Income Test (cont)
 Resources                        Standard - 30 1/3      90.00
   Resource Limit          .00   Dependent Care           .00
   Total Resources         .00   Net Earned Income     600.30
 Gross Income Test                Net Unearned Income      .00
   Gross Income Limit      .00   Deemed Income            .00
   Gross Earned Income  690.30   Allocated Income         .00
   Net Unearned Income     .00   Net Income            600.00
   Deemed Income           .00   Grant Amount             .00
   Allocated Income        .00   Recoupment Amount        .00
 Total Gross Income     690.30   Benefit Amount           .00
 Net Income Test                  Previous Benefit         .00
   Net Income Limit    2768.00   Spenddown Amount
   Gross Earned Income  690.30   Medical Expense Amt
   Self Employ Work Exp    .00   Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm  Y  Reasons            Budgeting Method P
 Notice Type 0004          Waive Timely Ntc Period         Notice Override
  Review Begin Date 10 06   Review End Date 99 99           Strat 1
 Message

  13-note
```

FPME

- Enter Y to finalize

RSM APPLICATION – RUTH CUMMINGS
INDEPENDENT STUDY

Background – Ms. Ruth Cummings arrives in her local DFCS office on 10/2/06 to apply for Medicaid for herself and her child, Tom. They have never received Medicaid before. Clerical support staff registered applications for F01 and P01.

Ms. Cummings has never been married and she and her son, Tom, reside alone. Tom's father, Ron Smith, was killed in a car accident last month. Ms. Cummings has a pending application for RSDI benefits for Tom.

Ms. Cummings is pregnant and her EDD is 10/31/06 as verified by a statement from her physician.

Ms. Cummings states the AU does not have any liquid or non-liquid resources.

Ms. Cummings is employed full-time at the BP Gas Station located at 875 Buford Highway, Atlanta, GA. She began working on 3/12/05 and received her first paycheck on 3/19/05. She earns $7.00 per hour and works 40 hours per week. Ms. Cummings is paid weekly on Fridays. Ms. Cummings provides check stubs to verify her earnings and states the checks are representative of what she usually earns.

While Ms. Ruth Cummings is working, her mother, Susan Cummings provides child care. Susan Cummings resides next door to her daughter Ruth at 252 Main Street. Susan Cummings does not charge her daughter.

Prior Month – Ms. Cummings states she received medical service in August when she experienced some pregnancy-related complications. She provided her August check stubs with her application for Medicaid.

Process her request for Prior Months Medicaid coverage.

Add A Newborn

This is a five-step process:

Step 1 – Add the Newborn to the RSM Budget Group   **L**

Step 2 – Add a Newborn COA   **K**

Step 3 – Complete the interview   **O**

Step 4 – Process the applications   **P**

Step 5 – Finalize the F15 and F22 cases   **Q**

ADD A NEWBORN/BG MEMBER – ALLISON ARROYO WALK THROUGH

Background

Ms. Allison Arroyo (32) and her three year old daughter Andrea receive Medicaid. They live with her husband, Carlos (26).

Ms. Arroyo phones on 10/5/06 to report that she has given birth to a beautiful baby boy. She has named him Emanuel Arroyo and he was born on 10/2/06.

Conduct a telephone interview with Ms. Arroyo to register an F15 Newborn Medicaid application for Emanuel and add him to the RSM Budget Group.

The trainer will walk through this process.

Your Assignment

- Add Emanuel to the F22 Budget Group
- Add an F15 case to provide Medicaid coverage for Emanuel

The trainer will walk through this process.

ADD A PERSON

AMEN

- Select K to begin the Add A Person process

- Enter F22 AU ID #

NAME

- Information is pre-populated

- Press ENTER

MEMB – Emanuel Arroyo

- Date of birth is 10/02/06; verified by AR's statement

- Hispanic, black male

- SSN applied for at birth

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

F Name EMANUEL        MI     L Name ARROYO              Suf
Relationship CH   DOB (MM DD YYYY) 10 02 2006   V CS   Sex M
SSA/SSN Appl For B    SSN1              V      Race: B W A N P   Ethnic: L
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 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                  18-tbud                        24-del
```

NAME/SSN Clearance – Emanuel Arroyo

- Enter Y in Assign New Client ID

- Press ENTER

```
HRRS0070              CLIENT REGISTRATION SYSTEM   CICSV2    10/05/2006
                         NAME/SSN CLEARANCE                   09:09:15

 CLIENT ID L NAME              F NAME      MI   DOB    SEX    SSN
 000000001 ARROYO             EMANUEL       10 02 2006  M    000 00 0000
  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 L
       0016 POSSIBLE MATCHES             TYPE OF MATCH   PRIMARY NAME
 SEL CL ID   E CTY L NAME          F NAME      MI   DOB SEX RCE SSN    ALT
  901000026   044 ARROYO          EMANUEL        10022006 M B 000000000
  947000000   044 ARROYO          EMANUEL        10022006 M B 000000000
  902000005   044 ARROYO          EMANUEL        10022006 M B 000000000
  901000030   044 ARROYO          EMANUEL        10022006 M B 000000000
  901000032   044 ARROYO          EMANUEL        10022006 M B 000000000
  945000000   044 ARROYO          EMANUEL        10022006 M B 000000000




 ASSIGN IV-A CLIENT ID
 ASSIGN NEW CLIENT ID   Y                      NEXT MATCH TYPE

 F1-HELP F2-RFRSH F3-EXIT F7-UP F8-DN F9-CLT DET F10-PREV F11-CLT PART F12-MATCH
```

MEMB – Emanuel Arroyo

- Press ENTER

INCH

- Select only the RSM Child case

- Application date is 10/05/06

- Press PF4 to bypass warning message regarding printing an AFA

```
ADDPERSON                    INFORMED CHOICE - INCH                    INCH


 HOH Name ALLISON        ARROYO                 Client ID XXXX00283
 Indicate/add all programs the head of household wishes to apply for

   Ind        Program          Med COA           AU ID
    Y      MA MED ASST           F22          xxxx00190
           MA MED ASST           P01          xxxx00191



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

                           Appl Date 10 05 06

 Message 0013
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                                      18-tbud          20-afa

```

REDI

- Press PF4 to bypass warning message regarding scheduling an appointment

ADD A PROGRAM

AMEN

- Select L to begin the Add A Program process

NAME

- Information is pre-populated

- Press ENTER

KIND

- Enter Y to select AFDC Related Medicaid

- Press ENTER

CIRC

- No data to enter

- Press ENTER

MEMB – Allison Arroyo

- Update pregnancy data

- Press ENTER

```
ADDPROGRM                  HOUSEHOLD MEMBER - MEMB                  MEMB 01
                                                                        01
 Client ID XXXX00283     Del

 F Name ALLISON      MI     L Name ARROYO              Suf
 Relationship SE   DOB (MM DD YYYY) 09 12 1974    V CS    Sex F
 SSA/SSN Appl For     SSN1 999 11 XXXX    V CS    Race: B W A N P  Ethnic:  N
 Preg  N    Due Date                              Y N N N N

 Alternate Names      F Name    MI        L Name       Suf


```

MEMB – Carlos Arroyo

- Change relationship code from child to spousal parent

- Press ENTER

```
ADDPROGRM                  HOUSEHOLD MEMBER - MEMB                  MEMB 01
                                                                        01
 Client ID XXXX00284     Del

 F Name CARLOS       MI    L Name ARROY              Suf
 Relationship SP   DOB (MM DD YYYY) 12 02 1980    V CS    Sex M
 SSA/SSN Appl For     SSN1 999 22 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

```

MEMB – Andrea Arroyo

- Press ENTER

MEMB – Emanuel Arroyo

- Press ENTER

INCH

- Do not select F01

- Enter Y in Ind field below F01

- Enter MA in Program field

- Enter F15 in MA COA field

- Application date is 10/02/06

- Press PF4 to bypass the warning message regarding printing an AFA

```
 HRRS0070                CLIENT REGISTRATION SYSTEM     CICSV2      10/05/2006
                           NAME/SSN CLEARANCE                       09:09:15

 CLIENT ID L NAME              F NAME        MI    DOB      SEX      SSN
 000000001 ARROYO             EMANUEL            10 02 2006  M     000 00 0000
  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 L
     0016 POSSIBLE MATCHES              TYPE OF MATCH   PRIMARY NAME
 SEL CL ID   E CTY L NAME              F NAME       MI   DOB SEX RCE SSN    ALT
  901000026   044 ARROYO              EMANUEL         10022006 M B 000000000
  947000000   044 ARROYO              EMANUEL         10022006 M B 000000000
  902000005   044 ARROYO              EMANUEL         10022006 M B 000000000
  901000030   044 ARROYO              EMANUEL         10022006 M B 000000000
  901000032   044 ARROYO              EMANUEL         10022006 M B 000000000
  945000000   044 ARROYO              EMANUEL         10022006 M B 000000000




 ASSIGN IV-A CLIENT ID
 ASSIGN NEW CLIENT ID   Y                       NEXT MATCH TYPE
```


REDI

- Press PF4 to bypass warning message regarding scheduling an appointment

INTERVIEW

AMEN

- Select O

ADDR

- Information from Add A Program is pre-populated

- Press PF21 access the NARR screen for documentation

NARR

- Document the following on the NARR:

  TC - Ms. Arroyo phoned to report the birth of her new son, Emanuel Arroyo. Ms. Arroyo states Emanuel was born on 10/2/06. An F15 case was added to provide coverage for Emanuel. Emanuel was also added to the RSM Budget Group. Ms. Arroyo is the best source of information regarding the birth of her child.

```
UPDATE                      NARRATIVE - NARR                      NARR
                                                                    01

   10/05/2006 03:55 PM FM Family Medicaid Training 555-555-5555
   TC - Ms. Arroyo phoned to report the birth of her new son, Emanuel
   Arroyo.  Ms. Arroyo states Emanuel was born on 10/2/06.  An F15 case
   was added to provide coverage for Emmanuel.  Emanuel was also added
   to the RSM Budget Group.  Ms. Arroyo is the best source of information
   regarding the birth of her child.




                                                                    More
 MESSAGE
      13- bott
```

ADDR

- Press PF4 to bypass warning message

STAT A – F22

- Change Carlos's Relationship code to SP

- Delete Carlos's Rsn code

- Emanuel is a BG member (use code RP)

- Access ADT 2 to enter documentation

```
INTERVIEW                    ASSISTANCE STATUS - STAT                    STAT    A
Month 11 06                       8991   10 05 06                            01

 AU ID XXXX00190  Prog MA  Prog Type F  Prev ABD Type    Med COA F22   Claim N
    CO 044    LO 049    Load ID 1798    Conversion Date

  AU     AU Status  AU Stat    Appl     Begin    Pd Thru  ---Penalty----   Appeal
 Stat    Reasons     Date      Date      Date     Date    Type  End Date    Ind
  A                 100206    100206   100106
 -------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl     Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date         Date     Date   Date   T  Date
 ALLISO ARR   SE OT   Y    RP   A 100206       100206  100106
 CARLOS ARR   SP OT   Y    RP   A 100206       100206  100106
 ANDREA ARR   CH OT   Y    RE   A 100206       100206  100106
 EMANUE ARR   CH OT   Y    RP   P 100506       100506


 Message 0013 04
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                            20-rmen      22-alau(arch)      23-alau(curr)
```

STAT B – P01

- Change Carlos's Relationship code from child to spouse

STAT C – F15

- Relationship verified by AR's statement (enter OT)

- Enter N in Mandatory Include field for all members except Emanuel

- Enter NM in Financial Responsibility field for all members except Emanuel

- Enter Y in Mandatory Include field for Emanuel

- Enter PN in Financial Responsibility field for Emanuel

- Access ADT to enter documentation

```
 INTERVIEW                    ASSISTANCE STATUS - STAT              STAT   C
 Month 11 06                    8991   10 05 06                        01

 AU ID XXXXXXXX  Prog MA  Prog Type F  Prev ABD Type    Med COA F15   Claim N
    CO 044    LO 049    Load ID 1798    Conversion Date

  AU     AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty----  Appeal
 Stat    Reasons      Date      Date    Date     Date     Type End Date   Ind
  P                  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
 ALLISO ARR    SE OT  N    NM   P 100506       100206
 CARLOS ARR    SP OT  N    NM   P 100506       100206
 ANDREA ARR    CH OT  N    NM   P 100506       100206
 EMANUE ARR    CH OT  Y    PN   P 100506       100206




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

```
 UPDATE                     REMARKS - REMA                      REMA
 ***************************** MEDICAID STAT *****************************
   10/05/2006 04:10 PM FM Family Medicaid Training 555-555-5555
   LIST OTHER   NAME                RELAT        AGE      FIN RES {Y/N}
   HH MEMBERS  :ALLISON ARROYO_____ :MOTHER___  :_32__  :_N_____
   NOT  INCL   :CARLOS ARROYO_____ :FATHER___  :_26__  :_N_____
   IN THE AU   :ANDREA ARROYO_____ :SISTER__   :__3__  :_N_____
   INELIGIBLE/PENALIZED AU MEMBER? Y/N (N) IF YES, EXPLAIN:_____
   :_____
   EXPLAIN STEP PARENT SITUATION:_____
   TRACE RELATIONSHIPS AND DOCUMENT FINANCIAL RESPONSIBILITY:
   :_____
   LIM ELIGIBLE? Y/N (N) IF NO, EXPLAIN:INCOME EXCEEDS LIMIT_____
   CMD, AS NEEDED:_____
   DUAL ELIG AU MEMBER(S)/COA? EXPLAIN:_NEWBORN AND RSM_____
   3MP COVERAGE RQSTD.? Y/N(N) IF YES, MO. AND DETERMINATION FOR EA.:_____ _
   :_____
   CROSS REF AU#s FOR 3MP AND ONGOING:_____
   EXPLAIN USE OF 500 DENIAL CODE:_____
                                                                    More
 MESSAGE
   0019 UPDATE COMPLETED SUCCESSFULLY
   13-bott
```

DEM1 – Allison Arroyo

- Ethnicity code is incorrect

- Press PF16 to access CRS

CRS – Allison Arroyo

- Update ethnicity code

- Press ENTER

DEM1 – Allison Arroyo

- Married and living with spouse

- Pregnancy terminated on 10/2/06; verified by AR's statement

- Delete data in Number Expected fields

- Access REMA to enter documentation

SSNA – Allison Arroyo

- Press ENTER

DEM2 – Allison Arroyo

- No data to enter

- Press ENTER

DEM1 – Carlos Arroyo

- Last name is misspelled

- Ethnicity code is incorrect

- Press PF16 to access CRS

CRS – Carlos Arroyo

- Correct spelling of Mr. Arroyo's last name

- Update ethnicity code

- Press ENTER

DEM1 – Carlos Arroyo

- Married and living with spouse

- Access REMA to enter documentation

- Press ENTER

DEM2 – Carlos Arroyo

- No data to enter

- Press ENTER

DEM1 – Andrea Arroyo

- No data to enter

- Press ENTER

DEM2 – Andrea Arroyo

- Health Check referral made on 10/5/06

- Press ENTER

DEM1 – Emanuel Arroyo

- Enter 10/02/06 in SSN Application Date field

- Lives at home

- Does not receive SSI

- Press ENTER

DEM2 – Emanuel Arroyo

- U.S. Citizen; verified by AR's statement

- Health Check referral made on 10/5/06

- Press ENTER through remaining screens

ERRO

- Address any unresolved errors

ELIG A – F22

- Confirm the data

CAFI A – F22

- Confirm the data

ELIG B – P01

- Confirm the data

CAFI B – P01

- Confirm the data

ELIG C – F15

- Confirm the data

CAFI C – F15

- Confirm the data

DONE

- Commit to the database

PROCESS

AMEN

- Select P

APP1

- Select 10/06

ADDR

- Fastpath to DONE

DONE

- Commit to the database

APP1

- Return to AMEN

FINALIZE F22

AMEN

- Select Q

- Enter the F22 AU ID #

APP2

- Press ENTER

ELIG 10/06 – F22

- If correct, confirm the data

```
FINALIZE             NON-FINANCIAL ELIGIBILITY RESULTS - ELIG        ELIG    A
Month 10 06                      8991   10 05 06                         01

AU ID XXXX00190    Prog MA    Prog Type F    Med COA F22
Confirm Y

 AU    AU Status   AU Stat    Appl     Begin    Pd Thru  ---Penalty---
Stat    Reasons     Date      Date     Date      Date    Type  End Date
 A                 100206    100206   100106
------------------------------------------------------------------------------
First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
Name   Name         Incl Resp    Date          Date    Date   Date    T  Date
ALLISO ARR    SE OT   Y    RP   A 100206       100206  100106
CARLOS ARR    CH OT   Y    RP   A 100206 220   100206  100106
ANDREA ARR    CH OT   Y    RE   A 100206       100206  100106
EMANUE ARR    CH OT   Y    RP   A 100506       100506  100106




Message
```

CAFI 10/06 – F22

- If correct, confirm the data

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI        CAFI    A
Month 10 06
 AU ID XXXX00190   Prog MA   Prog Type F      Med COA  F22
                              Net Income Test (cont)
 Resources                   Standard - 30 1/3      90.00
   Resource Limit          .00  Dependent Care        175.00
   Total Resources         .00  Net Earned Income     948.29
 Gross Income Test              Net Unearned Income      .00
   Gross Income Limit      .00  Deemed Income            .00
   Gross Earned Income  1213.29 Allocated Income         .00
   Net Unearned Income     .00  Net Income            948.00
   Deemed Income           .00  Grant Amount             .00
   Allocated Income        .00  Recoupment Amount        .00
 Total Gross Income     1213.29 Benefit Amount           .00
 Net Income Test               Previous Benefit         .00
   Net Income Limit     2594.00 Spenddown Amount
   Gross Earned Income  1213.29 Medical Expense Amt
   Self Employ Work Exp    .00  Net Spenddown Amt
 Bnft Eff Date 100206  Bnft Confirm y   Reasons 324       Budgeting Method P
 Notice Type            Waive Timely Ntc Period           Notice Override
  Review Begin Date 10 06   Review End Date 04 07          Strat 2
 Message

   13-note
```

ELIG 11/06 – F22

- If correct, confirm the data

```
 FINALIZE           NON-FINANCIAL ELIGIBILITY RESULTS - ELIG      ELIG    A
 Month 11 06                    8991   10 05 06                     01

 AU ID XXXX00190    Prog MA    Prog Type F    Med COA F22
 Confirm Y

  AU    AU Status   AU Stat    Appl     Begin    Pd Thru  ---Penalty---
  Stat    Reasons     Date     Date      Date     Date    Type  End Date
  A                 100206   100206   100106
 ----------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date         Date    Date   Date   T  Date
 ALLISO ARR   SE OT   Y    RP   A 100206      100206  100106
 CARLOS ARR   SP OT   Y    RP   A 100206      100206  100106
 ANDREA ARR   CH OT   Y    RE   A 100206      100206  100106
 EMANUE ARR   CH OT   Y    RP   A 100506      100506  100106




 Message
```

CAFI 11/06 – F22

- If correct, confirm the data

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI           CAFI    A
Month 11 06
 AU ID XXXX00190   Prog MA   Prog Type F      Med COA  F22
                             Net Income Test (cont)
 Resources                           Standard - 30 1/3      90.00
   Resource Limit              .00   Dependent Care         175.00
   Total Resources             .00   Net Earned Income      948.29
 Gross Income Test                   Net Unearned Income      .00
   Gross Income Limit          .00   Deemed Income            .00
   Gross Earned Income     1213.29   Allocated Income         .00
   Net Unearned Income         .00   Net Income             948.00
   Deemed Income               .00   Grant Amount             .00
   Allocated Income            .00   Recoupment Amount        .00
 Total Gross Income        1213.29   Benefit Amount           .00
 Net Income Test                     Previous Benefit         .00
   Net Income Limit        2594.00   Spenddown Amount
   Gross Earned Income     1213.29   Medical Expense Amt
   Self Employ Work Exp        .00   Net Spenddown Amt
 Bnft Eff Date 100206  Bnft Confirm Y   Reasons 324          Budgeting Method P
 Notice Type              Waive Timely Ntc Period          Notice Override
  Review Begin Date 10 06   Review End Date 04 07            Strat 2
 Message

  13-note
```

APP2

- Finalize the F22 application

FINALIZE F15

AMEN

- Select Q to finalize the application

- Press ENTER

APP2

- Press ENTER

ELIG 10/06 – F15

- If correct, enter Y to confirm the data

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

AU ID XXXXXXXXX     Prog MA    Prog Type F     Med COA F15
Confirm Y

 AU    AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
Stat    Reasons     Date      Date     Date      Date   Type  End Date
 A                 100506    100206   100106
----------------------------------------------------------------------------
First  Last  Rel V  Mand Finl   --Stat-- Rsn   Appl   Begin  Pd Thru  Penalty
Name   Name         Incl Resp     Date         Date   Date   Date     T  Date
ALLISO ARR    SE OT   N    NM   A 100506        100206
CARLOS ARR    SP OT   N    NM   A 100506        100206
ANDREA ARR    CH OT   N    NM   A 100506        100206
EMANUE ARR    CH OT   Y    RE   A 100506        100206 100106




Message
```

CAFI 10/06 – F15

- If correct, enter Y to confirm the data

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI         CAFI    A
Month 10 06
 AU ID XXXXXXXXX    Prog MA   Prog Type F      Med COA  F15
                              Net Income Test (cont)
Resources                      Standard - 30 1/3        .00
  Resource Limit         .00   Dependent Care           .00
  Total Resources        .00   Net Earned Income        .00
Gross Income Test              Net Unearned Income      .00
  Gross Income Limit     .00   Deemed Income            .00
  Gross Earned Income    .00   Allocated Income         .00
  Net Unearned Income    .00   Net Income               .00
  Deemed Income          .00   Grant Amount             .00
  Allocated Income       .00   Recoupment Amount        .00
Total Gross Income       .00   Benefit Amount           .00
Net Income Test                Previous Benefit         .00
  Net Income Limit       .00   Spenddown Amount
  Gross Earned Income    .00   Medical Expense Amt
  Self Employ Work Exp   .00   Net Spenddown Amt
Bnft Eff Date 100506  Bnft Confirm Y   Reasons          Budgeting Method P
Notice Type 0003      Waive Timely Ntc Period           Notice Override
 Review Begin Date 10 06   Review End Date 10 07          Strat 2
Message

 13-note
```

ELIG 11/06 – F15

- If correct, enter Y to confirm the data

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

AU ID XXXXXXXXX    Prog MA    Prog Type F    Med COA F15
Confirm Y

 AU    AU Status   AU Stat   Appl    Begin    Pd Thru  ---Penalty---
Stat    Reasons     Date     Date    Date      Date    Type  End Date
 A                 100506   100206   100106
-------------------------------------------------------------------------------
First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
Name   Name         Incl Resp    Date         Date    Date   Date    T  Date
ALLISO ARR    SE OT   N    NM   A 100506      100206
CARLOS ARR    SP OT   N    NM   A 100506      100206
ANDREA ARR    CH OT   N    NM   A 100506      100206
EMANUE ARR    CH OT   Y    RE   A 100506      100206  100106




Message
```

CAFI 11/06 – F15

- If correct, enter Y to confirm the data

```
FINALIZE            CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
Month 11 06
 AU ID 48322xxxx   Prog MA    Prog Type F      Med COA  F15
                              Net Income Test (cont)
 Resources                     Standard - 30 1/3        .00
   Resource Limit        .00   Dependent Care           .00
   Total Resources       .00   Net Earned Income        .00
 Gross Income Test             Net Unearned Income      .00
   Gross Income Limit    .00   Deemed Income            .00
   Gross Earned Income   .00   Allocated Income         .00
   Net Unearned Income   .00   Net Income               .00
   Deemed Income         .00   Grant Amount             .00
   Allocated Income      .00   Recoupment Amount        .00
 Total Gross Income      .00   Benefit Amount           .00
 Net Income Test               Previous Benefit         .00
   Net Income Limit      .00   Spenddown Amount
   Gross Earned Income   .00   Medical Expense Amt
   Self Employ Work Exp  .00   Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm y   Reasons          Budgeting Method P
 Notice Type 0003       Waive Timely Ntc Period          Notice Override
  Review Begin Date 10 06   Review End Date 10 07          Strat 2

Message
      13-note
```

APP2

- Enter Y to finalize the F15 application

ADD A NEWBORN/BG MEMBER – SUSAN NELSON INDEPENDENT STUDY

Background – Ms. Susan Nelson (27) lives with her husband, Ralph (27), and their two children, Brenda (1) and Marcus (6). She and her children were recently approved for RSM Medicaid. Her family's income was over the gross income ceiling for LIM.

She phones on 10/5/06 to report that she has given birth to a beautiful baby girl.

Her daughter's name is Donna Sue Nelson and she was born on 10/5/06. Donna is a white female and was enumerated at birth.

Your Assignment

- Use the five-step process to complete this change.
- Add Donna to the RSM Budget Group
- Add an F15 case to provide Newborn Medicaid coverage for Donna.
- Complete the interview and process the applications.
- Finalize the F22 add a person
- Switch AU ID #s with a peer and finalize the F15 application.

ADD A PERSON

AMEN

- Select K to begin the Add A Person process

- Enter F22 AU ID #

NAME

- Information is pre-populated

- Press ENTER

MEMB – Donna Sue Nelson

- Date of birth is 10/05/06; verified by AR's statement

- Non-ethnic, white female

- SSN applied for at birth

NAME/SSN Clearance – Donna Sue Nelson

- Enter Y in the Assign New Client ID Number field

- Press ENTER

MEMB – Donna Sue Nelson

- Press ENTER

INCH

- Select only the RSM Child case

- Application date is 10/05/06

- Press PF4 to bypass warning message regarding printing an AFA

REDI

- Press PF4 to bypass warning message regarding scheduling an appointment

ADD A PROGRAM

AMEN

- Select L to begin the Add A Program process

NAME

- Information is pre-populated

KIND

- Enter Y to select AFDC Related Medicaid

CIRC

- No data to enter

MEMB – Susan Nelson

- Update pregnancy data

MEMB – Ralph Nelson

- Data is pre-populated

MEMB – Brenda Nelson

- Data is pre-populated

MEMB – Marcus Nelson

- Data is pre-populated

MEMB – Donna Sue Nelson

- Data is pre-populated

INCH

- Do not select F01

- Enter Y in Ind field below F01

- Enter MA in Program field

- Enter F15 in MA COA field

- Application date is 10/05/06

- Press PF4 to bypass the warning message regarding printing an AFA

REDI

- Press PF4 to bypass warning message regarding scheduling an appointment

INTERVIEW

AMEN

- Select O

ADDR

- Access NARR to enter documentation

STAT A – F22

- Donna is a BG member (use code RP)

- Access ADT 2 to enter documentation

STAT B – P01

- No data to enter

STAT C – F15

- Relationship verified by AR's statement (enter OT)

- Enter N in Mandatory Include field for all members except Donna Sue

- Enter NM in Financial Responsibility field for all members except Donna Sue

- Enter Y in Mandatory Include field for Donna Sue

- Enter PN in Financial Responsibility field for Donna Sue

- Access ADT to enter documentation

DEM1 – Susan Nelson

- Married

- Pregnancy terminated on 10/5/06; verified by AR's statement

- Delete data in Number Expected fields

DEM2 – Susan Nelson

- No data to enter

DEM1 – Ralph Nelson

- Married

DEM2 – Ralph Nelson

- No data to enter

DEM1 – Brenda Nelson

- No data to enter

DEM2 – Brenda Nelson

- Health Check referral made on 10/5/06

DEM1 – Marcus Nelson

- No data to enter

DEM2 – Marcus Nelson

- Health Check referral made on 10/5/06

DEM1 – Donna Sue Nelson

- SSN Application Date is 10/05/06

- Lives at home

- Does not receive SSI

DEM2 – Donna Sue Nelson

- U.S. Citizen; verified by AR's statement

- Health Check referral made on 10/5/06

RES1 – MISC

- No data to enter

ELIG B – P01

- Confirm the data

CAFI B – P01

- Confirm the data

ELIG C – F22

- Confirm the data

CAFI C – F22

- Confirm the data

DONE

- Commit to the database

PROCESS

AMEN

- Select P

APP1

- Select 10/06

ADDR

- Fastpath to DONE

DONE

- Commit to the database

APP1

- Return to AMEN

FINALIZE F22

AMEN

- Select Q

- Enter the F22 AU ID #

APP2

- Press ENTER

ELIG 10/06 – F22

- If correct, confirm the data

CAFI 10/06 – F22

- If correct, confirm the data

ELIG 11/06 – F22

- If correct, confirm the data

CAFI 11/06 – F22

- If correct, confirm the data

APP2

- Finalize the F22 application

FINALIZE F15

AMEN

- Select Q to finalize the application

- Enter the F15 AU ID #

APP2

- Press ENTER

ELIG 10/06 – F15

- If correct, confirm the data

CAFI 10/06 – F15

- If correct, confirm the data

ELIG 11/06 – F15

- If correct, confirm the data

CAFI 11/06 – F15

- If correct, confirm the data

Congratulations!

APP2

- Finalize the F15 application

Allocated and Deemed Income
(MR 2661)

Allocating and Deeming of income are two special budgeting procedures.

Allocate: Use the income of an AU member to meet the needs of a non-AU member for whom s/he is legally obligated to support

AU

$
Stepfather   Mother

Her child
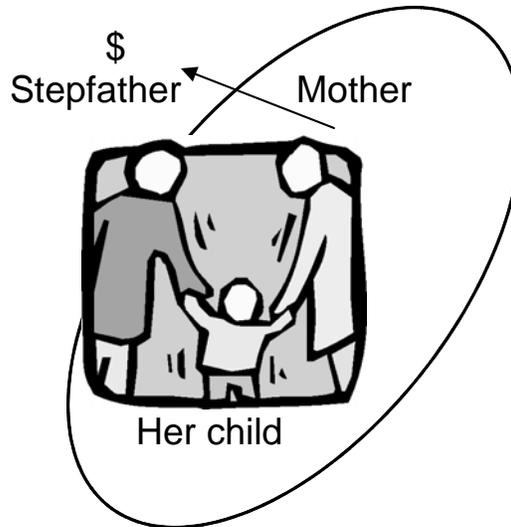
Deem: Use the income of a non-AU member to meet the needs of an AU member for whom s/he is obligated to support

$

Stepfather   Mother

AU

Her child
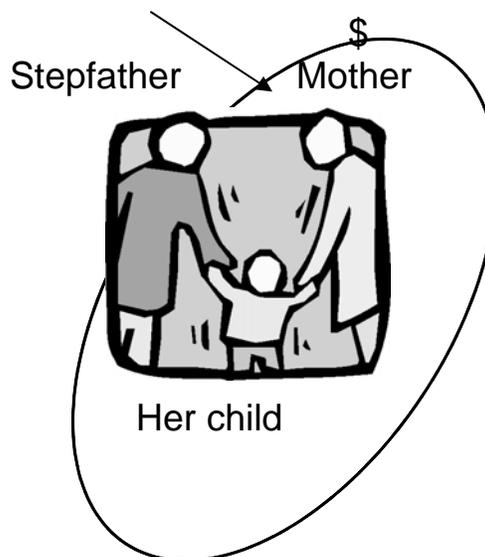
STEPPARENT SITUATION: COMPLETING A RESPONSIBILITY BUDGET

ALLOWABLE DEDUCTIONS

♦ $90/month Standard Work Expense

♦ An amount equal to the SON for the stepparent plus all of his/her legal federal tax dependents living in the home who are ineligible to be included in the LIM AU.

♦ Actual verified amounts paid to legal tax dependents living outside of the home.

♦ Actual verified alimony and/or child support paid to persons living outside of the home.

BUDGETING STEPS

STEP 1   Determine the gross earned income of the stepparent.

STEP 2   Subtract $90 from the gross earned income.

STEP 3   Add any countable unearned income of the stepparent.

STEP 4   Determine the number of individuals living in the home with the stepparent who is or could be claimed as a federal tax dependent. Include in this count the stepparent. Subtract the SON for this number of individuals.

STEP **5**   Subtract any amount paid by the stepparent to an individual living outside of the home who is or could be claimed as a federal tax dependent.

STEP 6   Subtract any alimony or child support paid by the stepparent to individuals not living in the home.

STEP 7   If a surplus exists, deem excess income up to the SON for one to the LIM AU.

If a deficit exists, there is no income to deem from the step-parent to the LIM AU. Consider allocation.

BLENDED FAMILY EXAMPLE
PARENTS MARRIED

Ms. Jones applies for Medicaid on 1/13. She has 3 children, Brian (4), Steve (5), and Ana (2). James Smith, who is Ana's father, also lives in the home. Ms. Jones and Mr. Smith are married. The household's income consists of $250/month child support received for Brian and Steve and Mr. Smith's monthly wages of $1083.32. Mr. Smith pays $200/month child support to his ex-wife for his son, David. Ms. Jones is not pregnant.

A. Consider LIM for everyone.

See Budget #1: The AU is ineligible for LIM.

B. Consider LIM for Ms. Jones and her sons.

See Budget #2: A responsibility budget is completed to deem income from Mr. Smith to his spouse Ms. Jones.

See Budget #3: Ms. Jones and her sons are ineligible for LIM.

C. Consider RSM for Anna, Brian and Steven.

See Budget #4: Everyone is included in the RSM BG. The three children will be covered under RSM; there is no coverage for Ms. Jones or Mr. Smith.

Georgia Department of Human Resources
TANF BUDGET SHEET

Budget #1
Parents - Married

Name of Grantee Relative **Ms. Jones**	Number in AU **5**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change

AU ID Number **113450112**	Effective Month **January**

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

A. Resource Test

Total Nonexempt Resources $ __0__
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ **1283.32**
(Plus deemed, less allocated income)
Gross Income Ceiling $ **1060**
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes   ☑ No

D. Eligibility/Payment Budget **AU is ineligible for LIM**			
1. ☐ SON ☐ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

DEEMING AND ALLOCATION WORKSHEET

Budget #2
Parents - Married

I. DETERMINATION OF SON FOR DEEMING BUDGET	**IV. DETERMINATION OF SON FOR ALLOCATION BUDGET**

I. DETERMINATION OF SON FOR DEEMING BUDGET

Responsible Individual:

- ☑ Stepparent
- ☐ Minor Caretaker's Parent(s)
- ☐ Ineligible Spouse
- ☐ Ineligible Parent
- ☐ Alien Sponsor

A. __1__ Number of responsible individual's children who live in the home but are not included in the AU

B. _____ Number of other dependents in the home who are claimed or could be claimed as tax dependents and are not included in the AU

C. __1__ Responsible Individual

D. __2__ Total

IV. DETERMINATION OF SON FOR ALLOCATION BUDGET

Persons to whom AU member's income can be allocated:

A. _____ Ineligible Spouse

B. _____ Ineligible Child(ren)

C. _____ Total

D. $_____ SON for Number in C

II. DEEMING BUDGET

$**1083.32** Earned Income

-$ **90.00** Earned Income Deduction

$ **993.32** Net Earned Income

$ **0** . Unearned Income

$ **993.32** Total Net Income

$ **356.00** Standard of Need (from 1D, above)

-$ **0** . Amount paid to dependents outside the household who are claimed or could be claimed as tax dependents

-$ **200.00** Alimony and/or child support paid to person(s) outside of the household

$ **437.32** Surplus/Deficit **$235 can be deemed to Ms. Jones**

V. Allocation Budget

Allocate the SON in D, or the gross income of the responsible AU member, whichever is less.

$_____ Gross AU Income

$_____ Less allocation

$_____ Amount to enter as gross income in GIC test

Ms. Jones married to Mr. Smith

Ana (daughter, 2)

Brian (son, 4)
Steve (son, 5)

III. DEEMING

If a surplus exists, deem this amount to the AU, and include the appropriate amount of the surplus in the amount of gross income in B (GIC Test), on the proper line in C (SON Test), and on line 10 in D (Eligibility/Payment Budget). If a deficit exists, there is no income to deem. Instead, determine if allocation is appropriate. If so, proceed to IV.

VI. ALLOCATION

Subtract income to allocate from the gross income in B (GIC Test), from the income in C (SON Test), and enter on line 11 in D (Eligibility/Payment Budget).

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Georgia Department of Human Resources
TANF BUDGET SHEET

Budget #3
Parents - Married

Name of Grantee Relative **Ms. Jones**	Number in AU **3**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change
AU ID Number **113450112**	Effective Month **January**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ ____**0**____
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ ___**435**___
(Plus deemed, less allocated income)
Gross Income Ceiling $ ___**784**___
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes   □ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   **424**

		Subtotals	
1. ☑ SON □ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)	**200**	**200**	
10. Plus Deemed Income	**235**	**435**	
11. Less Allocation			
12. Total Countable Income		**435**	**435**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **Ms. Jones and her sons are ineligible for LIM**			
15. Benefit Amount **Consider RSM for the 3 children**			

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Georgia Department of Human Resources
TANF BUDGET SHEET

Budget #4
Parents - Married

Name of Grantee Relative **Ms. Jones**	Number in AU**/BG** **5**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change	
AU ID Number **113450112**	Effective Month **January**	**C. Standard of Need Test**	

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? □ Yes □ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? □ Yes □ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   **2859/2150**

1. □ SON ☑ RSM Limit			
2. Earned Income	**1083.32**		
Total Earned Income	**1083.32**	**Subtotals**	
3. Less $90	**90.00**	**993.32**	
4. Less $30	**Not Eligible**		
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income		**993.32**	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)	**200**	**1193.32**	
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**1193.32**	**1193**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**RSM Child eligible (1-6)**		
15.Benefit Amount			

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BLENDED FAMILY EXAMPLE
PARENTS NOT MARRIED

Ms. Jones applies for Medicaid on 1/13. She has 3 children, Brian (4), Steve (5), and Ana (2). James Smith, who is Ana's father, also lives in the home. Ms. Jones and Mr. Smith are not married. The household's income consists of $250/month child support received for Brian and Steve and Mr. Smith's monthly wages of $1083.32. Mr. Smith pays $200/month child support to his ex-wife for his son, David. Ms. Jones is not pregnant.

A. Consider LIM for everyone.

See Budget #1: The AU is ineligible for LIM.

B. Consider LIM for Ms. Jones and her sons.

See Budget #2: The AU is eligible for LIM.

C. Consider RSM for Ana.

See Budget #3: Everyone is included in the BG. The AU is eligible

Ms. Jones and her three children will be covered (LIM/RSM); there is no coverage for Mr. Smith.

GEORGIA DEPARTMENT OF HUMAN RESOURCES
TANF BUDGET SHEET

Budget #1
Parents - Not Married

Name of Grantee Relative **Ms. Jones**	Number in AU **5**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change

AU ID Number **113450112**	Effective Month **January**

A. Resource Test

Total Nonexempt Resources $ ___0___
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

B. Gross Income Ceiling Test

Gross Income $ **1283.32**
(Plus deemed, less allocated income)
Gross Income Ceiling $ **1060**
(Surplus/Deficit) $ _____
Eligible based on GIC test? ☐ Yes   ☑ No

D. Eligibility/Payment Budget   **AU is ineligible for LIM due to income**

1. ☐ SON ☐ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

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Georgia Department of Human Resources
TANF BUDGET SHEET

Budget #2
Parents - Not Married

Name of Grantee Relative **Ms. Jones**	Number in AU **3**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change

AU ID Number **113450112**	Effective Month **January**

C. Standard of Need Test

Gross Wages		$ _____
Less Standard Deduction	$90	$ _____
Less Child Care	$ _____	$ _____
Plus Unearned Income	$ _____	$ _____
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ _____
SON		$ _____
Surplus/Deficit		$ _____
Eligible for $30 + 1/3?	□ Yes	□ No

A. Resource Test

Total Nonexempt Resources $ ___0___
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ __200__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __784__
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes   □ No

D. Eligibility/Payment Budget

424

1. ☑ SON □ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)	**200**	**200**	
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**200**	**200**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **Ms. Jones and her sons are eligible for LIM**			
15. Benefit Amount **Consider RSM for Ana**			

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

Budget #3
Parents - Not Married

Name of Grantee Relative **Ms. Jones**	Number in AU/**BG** **5**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change

AU ID Number **113450112**	Effective Month **January**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? ☐ Yes   ☐ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes   ☐ No

C. Standard of Need Test

Gross Wages		$ _____
Less Standard Deduction	$90	$ _____
Less Child Care	$ _____	$ _____
Plus Unearned Income	$ _____	$ _____
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ _____
SON		$ _____
Surplus/Deficit		$ _____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **2859**

		Subtotals	
1. ☐ SON ☑ RSM Limit			
2. Earned Income	1083.32		
Total Earned Income	1083.32	**Subtotals**	
3. Less $90	90.00	993.32	
4. Less $30	**Not Eligible**		
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income		993.32	
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)	200	1193.32	
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		1193.32	1193
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**RSM Child eligible - Ana**		
15. Benefit Amount			

Form 239 (Rev. 03/2009)

More Examples of Blended Families

Ms. Verlinda Matthews receives LIM for herself and two children, Tony (8) and Jacob (6). On 9/9 she calls to report she married Tony's father, Larry Johnson on 9/5. Mr. Johnson receives $204 per week in Worker's Compensation. He pays $450 per month in child support to his ex-wife. Ms. Matthews receives $300 per month in child support from Jacob's father. She has a checking account with a balance of $89. Ms. Matthews is not pregnant. Mr. Johnson has a savings account with a balance of $725.00 and a 2001 Buick Century (FMV $4500, nothing owed) which he drives to work. The Case Manager completes action on 9/14 after verification was provided.

A. Mother and two children receive LIM

B. Mother marries the father of one of her children. There is now a Blended Family.

C. Budgets completed to determine continued LIM eligibility.

   1) LIM budget completed including everyone in the AU; ineligible for LIM.

   2) Responsibility budget completed to determine the amount of income available to deem from Mr. Johnson to Ms. Matthews (his wife).

   3) Deem up to $235. Ms. Matthews and Jacob are eligible for LIM.

D. Budget completed to determine RSM eligibility for Tony.

   1) Ms. Matthews, Mr. Johnson, Tony and Jacob are included in the BG.

   2) Tony is eligible for RSM.

Child Support Received: $300/month

Child Support Paid: $450/month

WC: $204/wk
Savings: $725

Checking Account: $89

Ms. Matthews & Mr. Johnson

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative **Verlinda Matthews**	Number in AU **4**	**Action Taken:** ☑ Trial ☐ Initial ☐ Review ☑ Change
AU ID Number **522847650**	Effective Month **October**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ __814__
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ __1133.99__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __925__
(Surplus)/Deficit $ _____
Eligible based on GIC test? ☐ Yes   ☑ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **LIM AU Ineligible**

		Subtotals	
1. ☐ SON ☐ RSM Limit			
2. Earned Income			**WC $204.00 x4.3333**
Total Earned Income		**Subtotals**	**$883.99**
3. Less $90			**Child Support $300.00 - 50.00**
4. Less $30			
5. Less 1/3			
6. Less Child Care			**$250.00**
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

Ms. Matthews   Larry Johnson

Tony

Jacob

Form 239 (Rev. 03/2009)

DEEMING AND ALLOCATION WORKSHEET

I. DETERMINATION OF SON FOR DEEMING BUDGET	IV. DETERMINATION OF SON FOR ALLOCATION BUDGET

I. DETERMINATION OF SON FOR DEEMING BUDGET

Responsible Individual:

☑ Stepparent
☐ Minor Caretaker's Parent(s)
☐ Ineligible Spouse
☐ Ineligible Parent
☐ Alien Sponsor

A. __1__ Number of responsible individual's children who live in the home but are not included in the AU
B. _____ Number of other dependents in the home who are claimed or could be claimed as tax dependents and are not included in the AU
C. __1__ Responsible Individual
D. __2__ Total

IV. DETERMINATION OF SON FOR ALLOCATION BUDGET

Persons to whom AU member's income can be allocated:

A. _____ Ineligible Spouse

B. _____ Ineligible Child(ren)

C. _____ Total

D. $_____ SON for Number in C

II. DEEMING BUDGET

$_____ Earned Income
-$_____ Earned Income Deduction
$_____ Net Earned Income
$ **883.99** Unearned Income
$ **883.99** Total Net Income
$ **356.00** Standard of Need **(2) Mr. Johnson** (from 1D, above) **and Troy**
-$ **0** Amount paid to dependents outside the household who are claimed or could be claimed as tax dependents
-$ **450.00** Alimony and/or child support paid to person(s) outside of the household
$ **77.99** Surplus/Deficit **$77.99 can be deemed to Ms. Matthews**

V. Allocation Budget

Allocate the SON in D, or the gross income of the responsible AU member, whichever is less.

$_____ Gross AU Income

$_____ Less allocation

$_____ Amount to enter as gross income in GIC test

III. DEEMING

If a surplus exists, deem this amount to the AU, and include the appropriate amount of the surplus in the amount of gross income in B (GIC Test), on the proper line in C (SON Test), and on line 10 in D (Eligibility/Payment Budget). If a deficit exists, there is no income to deem. Instead, determine if allocation is appropriate. If so, proceed to IV.

VI. ALLOCATION

Subtract income to allocate from the gross income in B (GIC Test), from the income in C (SON Test), and enter on line 11 in D (Eligibility/Payment Budget).

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GEORGIA DEPARTMENT OF HUMAN RESOURCES
TANF BUDGET SHEET

Name of Grantee Relative **Verlinda Matthews**	Number in AU **2**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change		
AU ID Number **522847650**	Effective Month **October**	**C. Standard of Need Test**		

A. Resource Test

Total Nonexempt Resources $ ____**89**____
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ __**327.99**__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __**659**__
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes ☐ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **356**

		Subtotals	
1. ☑ SON ☐ RSM Limit			
2. Earned Income			**Child Support $300.00**
			- 50.00
			$250.00
Total Earned Income		Subtotals	
3. Less $90			**Deemed Income $77.99**
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)	250.00	250.00	
10. Plus Deemed Income	77.99	327.99	
11. Less Allocation			
12. Total Countable Income		327.99	328
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**LIM Eligible AU – Ms. Matthews & Jacob**		
15. Benefit Amount			

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Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative **Verlinda Matthews**	Number in AU/**BG** **4**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change	
AU ID Number **688723459**	Effective Month **October**	**C. Standard of Need Test**	

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? ☐ Yes ☐ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes ☐ No

C. Standard of Need Test

Gross Wages		$ _____
Less Standard Deduction	$90	$ _____
Less Child Care	$ _____	$ _____
Plus Unearned Income	$ _____	$ _____
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ _____
SON		$ _____
Surplus/Deficit		$ _____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget — **1838**

		Subtotals	
1. ☐ SON ☑ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income **Worker's Comp**	883.99	883.99	
9. Plus Child Support (Less $50 – Medicaid only)	250.00	1133.99	
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		1133.99	1134
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **RSM Child eligible - Tony**			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

More Examples of Blended Families

2.   Ms. Carla Franklin receives LIM for herself and 3 children: Angie (12), Carrie (4) and Billy (2). She marries Bob Tucker, the father of Carrie and Billy, on 3/15. Mr. Tucker receives $1680 per month from a trust fund. This change is reported and verified on 3/16. Ms. Franklin and her children have no income or resources.

   A.   Mother and three children receive LIM.

   B.   Mother marries the father of two of her children - Billy and Carrie. This is now a blended family.

   C.   Budgets completed to determine LIM eligibility for AU.

      1)   LIM budget based on AU of five (Budget #1). Mr. Tucker's income meets the needs of Carrie and Billy. Therefore, they are not all eligible to receive LIM. Consider RSM and LIM.

      2)   Complete budget(s) to determine LIM eligibility for Ms. Franklin and Angie.

            Responsibility budget completed to determine amount of income available to deem to Ms. Franklin. (Budget #2, Step 1).

            Deem $235 to Ms. Franklin (Budget #2, Step 2). Ms. Franklin and Angie are eligible for LIM.

      Note: Remember the AU does not have other income, they will be eligible for LIM based on the deemed income.

   D.   RSM budget completed to determine eligibility for Carrie and Billy (Budget #3). All are included in the BG. Carrie and Billy are eligible for RSM. Mr. Tucker is not eligible for Medicaid.

GEORGIA DEPARTMENT OF HUMAN RESOURCES
TANF BUDGET SHEET

Budget #1

Name of Grantee Relative **Carla Franklin**	Number in AU **5**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **522376480**	Effective Month **April**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ __0__
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ **1680**
(Plus deemed, less allocated income)
Gross Income Ceiling $ **1060**
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes ☑ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **LIM AU - Ineligible**

1. ☑ SON ☐ RSM Limit		
2. Earned Income		
Total Earned Income		**Subtotals**
3. Less $90		
4. Less $30		
5. Less 1/3		
6. Less Child Care		
7. Net Earned Income		
8. Plus Unearned Income		
9. Plus Child Support (Less $50 – Medicaid only)		
10. Plus Deemed Income		
11. Less Allocation		
12. Total Countable Income		
13. Surplus/Deficit (SON less line 12)		
14. Family Maximum		
15. Benefit Amount		

Ms. Franklin   Mr. Tucker

Carrie (4)
Billy (2)

Angie (12)

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DEEMING AND ALLOCATION WORKSHEET   **Step 1**
Budget #2

I. DETERMINATION OF SON FOR DEEMING BUDGET	**IV. DETERMINATION OF SON FOR ALLOCATION BUDGET**

Responsible Individual:

☒ Stepparent
☐ Minor Caretaker's Parent(s)
☐ Ineligible Spouse
☐ Ineligible Parent
☐ Alien Sponsor

A. __2__ Number of responsible individual's children who live in the home but are not included in the AU
B. _____ Number of other dependents in the home who are claimed or could be claimed as tax dependents and are not included in the AU
C. __1__ Responsible Individual
D. __3__ Total

Persons to whom AU member's income can be allocated:

A. _____ Ineligible Spouse

B. _____ Ineligible Child(ren)

C. _____ Total

D. $_____ SON for Number in C

II. DEEMING BUDGET

$_____ Earned Income

-$_____ Earned Income Deduction

$_____ Net Earned Income

$**1680.00** Unearned Income

$**1680.00** Total Net Income

$ **424.00** Standard of Need **(3) Mr. Tucker,** (from 1D, above) **Carrie & Billy**

-$ **0** Amount paid to dependents outside the household who are claimed or could be claimed as tax dependents

-$ **0** Alimony and/or child support paid to person(s) outside of the household

$**1256.00** Surplus/Deficit **$235.00 can be deemed to Ms. Franklin**

V. Allocation Budget

Allocate the SON in D, or the gross income of the responsible AU member, whichever is less.

$_____ Gross AU Income

$_____ Less allocation

$_____ Amount to enter as gross income in GIC test

III. DEEMING

If a surplus exists, deem this amount to the AU, and include the appropriate amount of the surplus in the amount of gross income in B (GIC Test), on the proper line in C (SON Test), and on line 10 in D (Eligibility/Payment Budget).
If a deficit exists, there is no income to deem. Instead, determine if allocation is appropriate. If so, proceed to IV.

VI. ALLOCATION

Subtract income to allocate from the gross income in B (GIC Test), from the income in C (SON Test), and enter on line 11 in D (Eligibility/Payment Budget).

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Georgia Department of Human Resources
TANF BUDGET SHEET

Step 2
Budget #2

Name of Grantee Relative **Carla Franklin**	Number in AU **2**	Action Taken: ☑ Trial □ Initial □ Review ☑ Change

AU ID Number **522376480**	Effective Month **April**

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

A. Resource Test

Total Nonexempt Resources $ ____**0**____
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ __**235**__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __**659**__
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes □ No

D. Eligibility/Payment Budget   **356**

		Subtotals	
1. ☑ SON □ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income	**235**	**235**	
11. Less Allocation			
12. Total Countable Income		**235**	**235**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **LIM AU Eligible – Ms. Franklin and Angie**			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative **Carla Franklin**	Number in AU/**BG** **5**	Action Taken: ☑ Trial ☑ Initial ☐ Review ☐ Change
AU ID Number **632274618**	Effective Month **April**	**C. Standard of Need Test**

A. Resource Test Total Nonexempt Resources $ _____ Resource Limit $1000 Eligible Based on Resources? ☐ Yes ☐ No		Gross Wages $_____ Less Standard Deduction $90 $_____ Less Child Care $_____ $_____ Plus Unearned Income $_____ $_____ Plus Deemed Income $_____ $_____ Less Allocation $_____ $_____ Total $_____ SON $_____ Surplus/Deficit $_____ Eligible for $30 + 1/3? ☐ Yes ☐ No
B. Gross Income Ceiling Test Gross Income $ _____ (Plus deemed, less allocated income) Gross Income Ceiling $ _____ Surplus/Deficit $ _____ Eligible based on GIC test? ☐ Yes ☐ No		

D. Eligibility/Payment Budget   **2859**

		Subtotals	
1. ☐ SON ☑ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income **Trust**	**1680**	**1680**	
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**1680**	**1680**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**RSM Child eligible – Carrie & Billy**		
15.Benefit Amount			

Form 239 (Rev. 03/2009)

More Examples of Blended Families

3.   Ms. Kim Hunter lives with her boyfriend Kevin Johnson, her child Traci (6), and their child John (3). Ms. Hunter applies for Medicaid on 7/10. She is employed and earns $100/week. Ms. Hunter is paid each Thursday. Mr. Johnson is also employed and earns $250/week; he is paid each Friday. Ms. Hunter provides the following pay check stubs:

Ms. Hunter		**Mr. Johnson**	
7/9	$100	7/3	$250
7/2	$100	6/26	$250
6/25	$100	6/19	$250
6/18	$100	6/12	$250
6/11	$100		

A.   Budget completed to determine LIM eligibility for AU. LIM budget is based on AU of 4. Ms. Hunter and Mr. Johnson are parents to John even though they are not married. The AU is ineligible for LIM with everyone included. (See Budget #1)

B.   Budget completed to determine LIM eligibility for Ms. Hunter and Traci. Since Ms. Hunter and Mr. Johnson are not married, he is not financially responsible for her; income is not deemed. Ms. Hunter and Traci are eligible for LIM. (See Budget #2)

C.   John cannot receive LIM. A budget is completed to determine his eligibility for RSM. Ms. Hunter, Mr. Johnson, Traci, and John are included in the RSM BG. John is eligible for RSM. Mr. Johnson is not eligible for Medicaid.

GEORGIA DEPARTMENT OF HUMAN RESOURCES
TANF BUDGET SHEET

Budget #1

Name of Grantee Relative **Kim Hunter**	Number in AU **4**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **447216893**	Effective Month **July**

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

A. Resource Test

Total Nonexempt Resources $ ___0___
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ **1516.65**
(Plus deemed, less allocated income)
Gross Income Ceiling $ **925**
(Surplus/Deficit) $ _____
Eligible based on GIC test? ☐ Yes ☑ No

D. Eligibility/Payment Budget   **LIM AU Ineligible**

1. ☑ SON ☐ RSM Limit			
2. Earned Income			**Wages** **$100.00** **x 4.3333** **$433.33**
Total Earned Income		**Subtotals**	
3. Less $90			**$250.00** **x 4.3333** **$1083.32**
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation		**Ms. Hunter Kevin Johnson**	
12. Total Countable Income		**John (3)**	
13. Surplus/Deficit (SON less line 12)		**Traci (6)**	
14. Family Maximum			
15. Benefit Amount			

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Georgia Department of Human Resources
TANF BUDGET SHEET

Budget #2

Name of Grantee Relative **Kim Hunter**	Number in AU **2**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **447216893**	Effective Month **July**

A. Resource Test

Total Nonexempt Resources $ __0__
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ __433.33__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __659__
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes ☐ No

C. Standard of Need Test

Gross Wages		$ __433.33__
Less Standard Deduction	$90	$ __343.33__
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$ __343__
SON		$ __356__
Surplus/Deficit		$_____
Need? Eligible for $30 + 1/3?	☐ Yes	☑ No

D. Eligibility/Payment Budget

356

1. ☑ SON ☐ RSM Limit				
2. Earned Income/**Wages – Ms. Hunter**	433.33			
Total Earned Income	433.33	**Subtotals**		
3. Less $90	90.00	343.33		
4. Less $30				
5. Less 1/3				
6. Less Child Care				
7. Net Earned Income		343.33		
8. Plus Unearned Income				
9. Plus Child Support (Less $50 – Medicaid only)				
10. Plus Deemed Income				
11. Less Allocation				
12. Total Countable Income				343
13. Surplus/Deficit (SON less line 12)				
14. Family Maximum **LIM AU Eligible – Ms. Hunter & Traci**				
15. Benefit Amount				

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Georgia Department of Human Resources
TANF BUDGET SHEET

Budget #3

Name of Grantee Relative **Kim Hunter**	Number in AU/**BG** **4**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change

AU ID Number **532738194**	Effective Month **July**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $ $1000
Eligible Based on Resources? □ Yes □ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? □ Yes □ No

C. Standard of Need Test

Gross Wages		$ _____
Less Standard Deduction	$90	$ _____
Less Child Care	$ _____	$ _____
Plus Unearned Income	$ _____	$ _____
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ _____
SON		$ _____
Surplus/Deficit		$ _____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget **2444**

1. □ SON ☑ RSM Limit		
2. Earned Income **Ms. Hunter**	433.33	
Mr. Johnson	1083.32	
Total Earned Income	1516.65	**Subtotals**
3. Less $90	180.00	1336.65
4. Less $30		
5. Less 1/3		
6. Less Child Care		
7. Net Earned Income		1336.65
8. Plus Unearned Income		
9. Plus Child Support (Less $50 – Medicaid only)		
10. Plus Deemed Income		
11. Less Allocation		
12. Total Countable Income		1336.65	1337
13. Surplus/Deficit (SON less line 12)		
14. Family Maximum	**RSM Child eligible – John**	
15. Benefit Amount		

Form 239 (Rev. 03/2009)

Family Medicaid
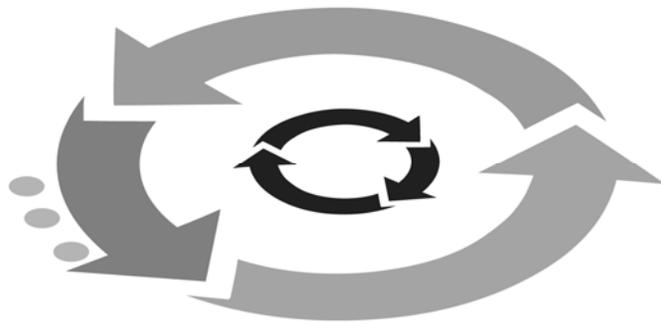
Participant Guide

CONTINUING MEDICAID DETERMINATION

Objectives

☐   Participants will be able to identify when a Continuing Medicaid Determination must be completed.

☐   Participants will be able to identify and refer children potentially eligible for PeachCare for Kids.

☐   Participants will be able to enter data and documentation in SUCCESS related to the CMD process.

Outline

I.   Introduction

II.   Continuing Medicaid Determination (MR 2052)

III.   PeachCare for Kids (MR 2194)

IV.   Allison Arroyo Walk Through SUCCESS Case

V.   Susan Nelson Independent Study SUCCESS Case

VI.   Ruth Cummings Walk Through SUCCESS Case

LIM Ineligibility Due to Parent with Income Moving Into Home

Ms. Cindy Andrews receives LIM for herself and three children, Patrick (14), John (12) and David (4). On 12/4 Ms. Andrews calls and reports that the children's father, Roger Metcalf, moved into the home on 12/1. Mr. Metcalf receives $1000 per month in retirement benefits; Ms. Andrews receives a $50 contribution each week on Wednesdays from her grandfather. She has $20 in her savings account. The Case Manager completes the action on 12/9 after verification was provided.

a. Who is eligible for Medicaid?

b. What categories of Medicaid will they receive?

c. What is the time period for each type of Medicaid?

GEORGIA DEPARTMENT OF HUMAN RESOURCES
TANF BUDGET SHEET

Name of Grantee Relative **Cindy Andrews**	Number in AU **5**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change

AU ID Number **487644290**	Effective Month **January**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ __**20**__
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ __**1216.66**__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __**1060**__
~~Surplus/~~Deficit $ _____
Eligible based on GIC test? □ Yes   ☑ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget   Ineligible for LIM

		Subtotals	
1. □ SON □ RSM Limit			
2. Earned Income			**Retirement $1,000**
Total Earned Income		**Subtotals**	**Contribution $50 x 4.3333 = $216.66**
3. Less $90			
4. Less $30			**LIM AU – Ms. Andrews, Mr. Metcalf, Patrick, John and David**
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income			
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income			
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum			
15. Benefit Amount			

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Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative **Cindy Andrews**	Number in AU/**BG** **5**	Action Taken: ☑ Trial ☑ Initial □ Review □ Change
AU ID Number **487644209**	Effective Month **January**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? □ Yes □ No

C. Standard of Need Test

Gross Wages		$ _____
Less Standard Deduction	$90	$ _____
Less Child Care	$ _____	$ _____
Plus Unearned Income	$ _____	$ _____
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ _____
SON		$ _____
Surplus/Deficit		$ _____
Eligible for $30 + 1/3?	□ Yes	□ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? □ Yes □ No

D. Eligibility/Payment Budget

2150 / 2859

1. □ SON ☑ RSM Limit				
2. Earned Income				
Total Earned Income				
3. Less $90				
4. Less $30				
5. Less 1/3				
6. Less Child Care				
7. Net Earned Income				
8. Plus Unearned Income	**Contribution** **Retirement**	**216.66** **1000.00**	**1216.66**	
9. Plus Child Support (Less $50 – Medicaid only)				
10. Plus Deemed Income				
11. Less Allocation				
12. Total Countable Income			**1216.66**	**1217**
13. Surplus/Deficit (SON less line 12)				
14. Family Maximum	**Eligible RSM Child (1-5) David**			
15. Benefit Amount	**Eligible RSM Child (6-19) Patrick and John**			

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LIM Ineligibility Due to the Income of a Child

Ms. Rogers receives LIM for herself and 2 children Melinda (4) and Michael (12). On 2/10 Ms. Rogers reports and verifies Michael has begun to receive $650 per month RSDI survivor's benefits. His first check was received on 2/1.

    a. Continued LIM eligibility is determined for the ongoing month.

    b. Since LIM ineligibility is due to the income of a child, exclude Michael and determine LIM eligibility for Ms. Rogers and Melinda.

    c. RSM is determined for Michael - all are included in the BG.

LIM   **RSM**

GEORGIA DEPARTMENT OF HUMAN RESOURCES
TANF BUDGET SHEET

Name of Grantee Relative **Ms. Rogers**	Number in AU **3**	Action Taken: ☑ Trial □ Initial □ Review ☑ Change

AU ID Number **111222333**	Effective Month **March**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ ___**0**___
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   □ No

B. Gross Income Ceiling Test

Gross Income $ __**650**__
(Plus deemed, less allocated income)
Gross Income Ceiling $ __**784**__
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes   □ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	□ Yes	□ No

D. Eligibility/Payment Budget			**424**
1. ☑ SON □ RSM Limit			
2. Earned Income			
Total Earned Income		**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income **RSDI**	**650.00**	**650.00**	
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**650.00**	**650**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **Ineligible for LIM**			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative **Ms. Rogers**	Number in AU **2**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change

AU ID Number **111222333**	Effective Month **March**	**C. Standard of Need Test**

A. Resource Test

Total Nonexempt Resources $ ___**0**___
Resource Limit $1000
Eligible Based on Resources? ☑ Yes   ☐ No

B. Gross Income Ceiling Test

Gross Income $ ___**0**___
(Plus deemed, less allocated income)
Gross Income Ceiling $ ___**784**___
Surplus/Deficit $ _____
Eligible based on GIC test? ☑ Yes   ☐ No

C. Standard of Need Test

Gross Wages		$_____
Less Standard Deduction	$90	$_____
Less Child Care	$_____	$_____
Plus Unearned Income	$_____	$_____
Plus Deemed Income	$_____	$_____
Less Allocation	$_____	$_____
Total		$_____
SON		$_____
Surplus/Deficit		$_____
Eligible for $30 + 1/3?	☐ Yes	☐ No

D. Eligibility/Payment Budget   **356**

1. ☑ SON ☐ RSM Limit			
2. Earned Income			
Total Earned Income	**0**	**Subtotals**	
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income	**0**		
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**0**	**0**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum	**LIM Eligible AU – Ms. Rogers and Melinda**		
15.Benefit Amount			

Form 239 (Rev. 03/2009)

Georgia Department of Human Resources
TANF BUDGET SHEET

Name of Grantee Relative **Ms. Rogers**	Number in AU/**BG** **3**	Action Taken: ☑ Trial ☐ Initial ☐ Review ☑ Change
AU ID Number **156735912**	Effective Month **March**	**C. Standard of Need Test**

A. Resource Test
Total Nonexempt Resources $ _____
Resource Limit $1000
Eligible Based on Resources? ☐ Yes   ☐ No

C. Standard of Need Test		
Gross Wages		$ _____
Less Standard Deduction	$90	$ _____
Less Child Care	$ _____	$ _____
Plus Unearned Income	$ _____	$ _____
Plus Deemed Income	$ _____	$ _____
Less Allocation	$ _____	$ _____
Total		$ _____
SON		$ _____
Surplus/Deficit		$ _____
Eligible for $30 + 1/3?	☐ Yes	☐ No

B. Gross Income Ceiling Test
Gross Income $ _____
(Plus deemed, less allocated income)
Gross Income Ceiling $ _____
Surplus/Deficit $ _____
Eligible based on GIC test? ☐ Yes   ☐ No

D. Eligibility/Payment Budget   **1526**

1. ☐ SON ☑ RSM Limit			
2. Earned Income			
Total Earned Income			
3. Less $90			
4. Less $30			
5. Less 1/3			
6. Less Child Care			
7. Net Earned Income			
8. Plus Unearned Income **RSDI**	**650.00**	**650.00**	
9. Plus Child Support (Less $50 – Medicaid only)			
10. Plus Deemed Income			
11. Less Allocation			
12. Total Countable Income		**650.00**	**650**
13. Surplus/Deficit (SON less line 12)			
14. Family Maximum **Eligible RSM Child (6-19) Michael**			
15. Benefit Amount			

Form 239 (Rev. 03/2009)

INCREASED INCOME – ALLISON ARROYO
WALK THROUGH

BACKGROUND

Mrs. Allison Arroyo lives with her husband, Carlos, their three year old daughter, Andrea and newborn son, Emanuel. Mrs. Arroyo, Andrea and Emanuel are all receiving Medicaid.

Mrs. Arroyo calls on 10/5/06 to report that her husband is employed. He was hired on 9/25/06 by Parker Construction Company and earns $11.25 per hour. He works 40 hours per week and received his first check on 10/2/06. Mrs. Arroyo faxed in a copy of the letter and check stub to the Case Manager.

When asked about childcare, Mrs. Arroyo states that she will continue to send Andrea to Children's Friends. They charge her $65/week. Since Emanuel is still a newborn, her mother, Mary Henderson, has agreed to take care of him at no charge.

The trainer will walk through this process.

STEP ONE

Complete a trial budget to determine if the AU remains eligible for any Family Medicaid class of assistance.

STEP TWO

Update the documentation and enter the required data. Complete any required CMDs.

Parker Construction Co.
101 Hwy 42
McDonough, GA 30232
678-994-5515

10/5/06

To Whom It May Concern:

Carlos Arroyo began working for us on 9/25/06. His first paycheck was received on 10/2/06. If you have any questions you may call our Payroll Department and speak with Peggy Rogers.

Sincerely,
Mark Wade
General Contractor

Parker Construction Company

Period End Date:	**9/28/2006**	Employee Name	**Carlos Arroyo**	**Employee ID**	**1465789**
Tax Status	**2**	Federal Allowance (From W-4)	**4**	Hours Worked	**40**
Hourly Rate	**$11.25**	Overtime Rate	**$0.00**	Sick Hours	**0**
Social Security Tax	**$10.35**	Federal Income Tax	**$18.00**	Vacation Hours	**0**
Medicare Tax	**$2.03**	State Tax	**$10.35**	Overtime Hours	**0**
Insurance Deduction	**$0.00**	Other Regular Deduction	**$0.00**	Gross Pay	**$450.00**
Total Taxes and Regular Deductions	**$40.73**	Other Deduction	**$0.00**	Total Taxes and Deductions	**$40.73**
Pay Date	**10/2/2006**			**Net Pay**	**$409.28**

TRIAL ELIGIBILITY

AMEN
- Select F

- Enter the F22 AU ID #

- Press ENTER

ADDR
- Fastpath to ERN1 for Carlos Arroyo

ERN1
- Enter employer data

- Press ENTER

ERN2
- Enter wage information

- Fastpath to DONE

ELIG

- Review eligibility

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

 AU ID XXXX00190    Prog MA    Prog Type F    Med COA F99
 Confirm

  AU    AU Status  AU Stat    Appl    Begin    Pd Thru   ---Penalty---
 Stat   Reasons     Date      Date     Date     Date     Type  End Date
  M    347         100506   100206   100106
 -------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date         Date    Date   Date    T Date
 ALLISO ARR   SE OT   Y    RP   A 100506 347  100206  100106
 CARLOS ARR   SP OT   Y    RP   A 100506 347  100206  100106
 ANDREA ARR   CH OT   Y    RE   A 100506 347  100206  100106
 EMANUE ARR   CH OT   Y    NM   A 100506 347  100506  100106




 Message
```

CAFI

- Review budget to ensure earnings are calculated correctly

```
CHANGE              CASH/MA FINANCIAL ELIGIBILITY - CAFI           CAFI    A
  Month 11 06
 AU ID XXXX00190   Prog MA   Prog Type F      Med COA  F99
                            Net Income Test (cont)
Resources                      Standard - 30 1/3      180.00
  Resource Limit      4100.00  Dependent Care         175.00
  Total Resources         .00  Net Earned Income     2808.27
Gross Income Test               Net Unearned Income      .00
  Gross Income Limit      .00  Deemed Income            .00
  Gross Earned Income 3163.27  Allocated Income         .00
  Net Unearned Income     .00  Net Income            2808.00
  Deemed Income           .00  Grant Amount             .00
  Allocated Income        .00  Recoupment Amount        .00
Total Gross Income    3163.27  Benefit Amount           .00
Net Income Test                 Previous Benefit         .00
  Net Income Limit     375.00  Spenddown Amount      2433.00
  Gross Earned Income 3163.27  Medical Expense Amt      .00
  Self Employ Work Exp    .00  Net Spenddown Amt     2433.00
Bnft Eff Date 101506  Bnft Confirm   Reasons 308 302 324   Budgeting Method P
Notice Type 0024      Waive Timely Ntc Period          Notice Override
 Review Begin Date 10 06   Review End Date 04 07        Strat 3
Message 1572     2115
1572 VERIFY RESOURCES SINCE AU HAS TRICKLED FROM RSM.
 13-note
```

PROCESS THE CHANGE

AMEN

- Select R

ADDR

- Access NARR to enter documentation

STAT A – F22

- Enter 518 in AU Status Reasons field

- Access ADT to enter documentation regarding the closure

- PeachCare for Kids application mailed to AR on 10/5/06

- Fastpath to ERN1 for Carlos Arroyo

```
CHANGE                        ASSISTANCE STATUS - STAT                  STAT    A
  Month 11 06                      8991   10 05 06                         01

 AU ID XXXX00190  Prog MA  Prog Type F  Prev ABD Type    Med COA F22   Claim N
    CO 044    LO 049    Load ID 1798    Conversion Date

  AU    AU Status  AU Stat   Appl    Begin    Pd Thru  ---Penalty----   Appeal
 Stat    Reasons    Date     Date     Date     Date   Type  End Date    Ind
  A     518        100206  100206   100106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl   --Stat-- Rsn  Appl    Begin  Pd Thru  Penalty
 Name   Name    Incl Resp     Date       Date    Date   Date   T  Date
 ALLISO ARR   SE OT  Y    RP   A 100206       100206  100106
 CARLOS ARR   SP OT  Y    RP   A 100206 220  100206  100106
 ANDREA ARR   CH OT  Y    RE   A 100206       100206  100106
 EMANUE ARR   CH OT  Y    RP   A 100506       100506  100106




 Message


                        20-rmen      22-alau(arch)     23-alau(curr)
```

ERN1 – Carlos Arroyo

- Enter employer information

- Access ADT to enter documentation

ERN2 – Carlos Arroyo

- Enter wage information

- Access ADT to enter documentation

- Fastpath to DONE

ERRO

- Address any unresolved errors

ELIG A – F22

- If correct, confirm the data

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

 AU ID XXXX00190     Prog MA     Prog Type F     Med COA F22
 Confirm Y

  AU     AU Status   AU Stat    Appl     Begin    Pd Thru  ---Penalty---
 Stat    Reasons      Date      Date     Date      Date    Type  End Date
  C     518          100506    100206   100106    10312006
 --------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl   --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date           Date   Date   Date    T  Date
 ALLISO ARR    SE OT  Y    RP   C 100506 518   100206  100106 10312006
 CARLOS ARR    SP OT  Y    RP   C 100506 518   100206  100106 10312006
 ANDREA ARR    CH OT  Y    RE   C 100506 518   100206  100106 10312006
 EMANUE ARR    CH OT  Y    RP   C 100506 518   100506  100106 10312006




 Message 2092 01
 2092 REVIEW PREGNANCY TERMINATION DATE
```

CAFI A – F22

- If correct, confirm the data

```
CHANGE              CASH/MA FINANCIAL ELIGIBILITY - CAFI         CAFI    A
Month 11 06
 AU ID XXXX00190   Prog MA   Prog Type F      Med COA  F22
                              Net Income Test (cont)
 Resources                    Standard - 30 1/3        .00
   Resource Limit       .00   Dependent Care           .00
   Total Resources      .00   Net Earned Income        .00
 Gross Income Test            Net Unearned Income      .00
   Gross Income Limit   .00   Deemed Income            .00
   Gross Earned Income  .00   Allocated Income         .00
   Net Unearned Income  .00   Net Income               .00
   Deemed Income        .00   Grant Amount             .00
   Allocated Income     .00   Recoupment Amount        .00
 Total Gross Income     .00   Benefit Amount           .00
 Net Income Test              Previous Benefit         .00
   Net Income Limit     .00   Spenddown Amount
   Gross Earned Income  .00   Medical Expense Amt
   Self Employ Work Exp .00   Net Spenddown Amt
 Bnft Eff Date 101506  Bnft Confirm Y   Reasons 518        Budgeting Method P
 Notice Type 0007         Waive Timely Ntc Period          Notice Override
  Review Begin Date 10 06   Review End Date 04 07           Strat 2
 Message

  13-note
```

ELIG B – P01

- If correct, confirm the data

```
CHANGE            NON-FINANCIAL ELIGIBILITY RESULTS - ELIG       ELIG    B
Month 11 06                    8991   10 05 06                    01

AU ID XXXX00191   Prog MA   Prog Type P   Med COA P01
Confirm Y

 AU    AU Status  AU Stat   Appl    Begin   Pd Thru  ---Penalty---
 Stat   Reasons    Date     Date     Date    Date    Type  End Date
 A                 100206   100206  100106
 ------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn  Appl   Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date       Date    Date   Date   T  Date
 ALLISO ARR   SE OT   Y    RE   A 100206     100206  100106
 CARLOS ARR   SP OT   Y    RP   A 100206     100206  100106
 ANDREA ARR   CH OT   Y    RP   A 100206     100206  100106




 Message
```

CAFI B – P01

- If correct, confirm the data

```
CHANGE                 CASH/MA FINANCIAL ELIGIBILITY - CAFI            CAFI    B
Month 11 06                        8991   10 05 06
 AU ID XXXX00191   Prog MA   Prog Type P      Med COA  P01
                                   Net Income Test (cont)
 Resources                         Standard - 30 1/3        .00
   Resource Limit            .00   Dependent Care           .00
   Total Resources           .00   Net Earned Income        .00
 Gross Income Test                 Net Unearned Income      .00
   Gross Income Limit        .00   Deemed Income            .00
   Gross Earned Income       .00   Allocated Income         .00
   Net Unearned Income       .00   Net Income               .00
   Deemed Income             .00   Grant Amount             .00
   Allocated Income          .00   Recoupment Amount        .00
 Total Gross Income          .00   Benefit Amount           .00
 Net Income Test                   Previous Benefit         .00
   Net Income Limit          .00   Spenddown Amount
   Gross Earned Income       .00   Medical Expense Amt
   Self Employ Work Exp      .00   Net Spenddown Amt
 Bnft Eff Date 100206  Bnft Confirm Y   Reasons            Budgeting Method P
 Notice Type 0011          Waive Timely Ntc Period          Notice Override
  Review Begin Date 10 06    Review End Date 99 99            Strat 2
 Message

  13-note
```

ELIG C – F15

- If correct, confirm the data

```
CHANGE                 NON-FINANCIAL ELIGIBILITY RESULTS - ELIG         ELIG    C
Month 11 06                        9991   10 05 06                      01

 AU ID XXXXXXXXX    Prog MA    Prog Type F    Med COA F15
 Confirm Y

  AU     AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
  Stat    Reasons     Date      Date    Date      Date    Type  End Date
  A                  100506   100206   100106
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date         Date    Date   Date    T  Date
 ALLISO ARR    SE OT   N    NM   A 100506     100206
 CARLOS ARR    SP OT   N    NM   A 100506     100206
 ANDREA ARR    CH OT   N    NM   A 100506     100206
 EMANUE ARR    CH OT   Y    RE   A 100506     100206  100106




 Message
```

CAFI C – F15

- If correct, confirm the data

```
CHANGE               CASH/MA FINANCIAL ELIGIBILITY - CAFI            CAFI    C
Month 11 06                  9991   10 05 06
 AU ID XXXXXXXX   Prog MA   Prog Type F       Med COA  F15
                              Net Income Test (cont)
 Resources                           Standard - 30 1/3         .00
   Resource Limit          .00   Dependent Care            .00
   Total Resources         .00   Net Earned Income         .00
 Gross Income Test                Net Unearned Income       .00
   Gross Income Limit      .00   Deemed Income             .00
   Gross Earned Income     .00   Allocated Income          .00
   Net Unearned Income     .00   Net Income                .00
   Deemed Income           .00   Grant Amount              .00
   Allocated Income        .00   Recoupment Amount         .00
 Total Gross Income        .00   Benefit Amount            .00
 Net Income Test                  Previous Benefit          .00
   Net Income Limit        .00   Spenddown Amount
   Gross Earned Income     .00   Medical Expense Amt
   Self Employ Work Exp    .00   Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y   Reasons            Budgeting Method P
 Notice Type 0003          Waive Timely Ntc Period          Notice Override
  Review Begin Date 10 06   Review End Date 10 07            Strat 2
 Message

  13-note
```

DONE

- Commit to the database

INCREASED INCOME – SUSAN NELSON
INDEPENDENT STUDY

Background

Mrs. Susan Nelson was recently approved for RSM PgW for herself; RSM Child Medicaid for her children, Brenda and Marcus; and Newborn Medicaid for her daughter, Donna. Her household also includes her husband, Ralph.

Mrs. Nelson phones on 10/5/06 to report that she has received a raise in pay. She is employed by Blind Willies and will now earn $20.00 per hour at 40 hours per week. This raise is effective on 11/1/06.

Mrs. Nelson states that her husband will continue to take care of the children while she works.

Your Assignment

- Complete trial eligibility to determine ongoing eligibility.

- Carefully review the verification provided.

- Process the reported change.

- Do not confirm the F22 if it trickles to F99.

- Close the F22 and mail a PeachCare for Kids application to the Nelson family.

10/8/06

To Whom It May Concern:

Mrs. Susan Nelson will begin to earn $800/week effective 11/1/06 due to her promotion as Supervisor. She will earn $20.00 per hour at 40 hours per week.

Max Williams, Owner
809 Crestline Way
Atlanta, GA 30303
404-555-1114

Blind Willies

DECREASED INCOME – RUTH CUMMINGS
WALK THROUGH

Background

Ms. Ruth Cummings and her son, Kyle, were recently approved for RSM. She has been employed at BP Gas since 2005. She phones on 10/5/06 to report that due to downsizing, BP has terminated her employment. Her last day of employment was today, 10/5/06, and she will receive her last check on 10/9/06.

Your Assignment

- Document the reported change

- Request verification

- Process the change once verification is provided

- Complete a CMD to determine ongoing eligibility

- Consider all Classes of Assistance

CONTINUING MEDICAID DETERMINATION

Ms. Barnett applies for RSM PgW on 10/15. She is due to deliver on 3/27. Her only income is gross wages of $775 per month.

I. RSM approved 10/20. Ms. Barnett covered by RSM PgW Medicaid through May.

Twins are born to Ms. Barnett March 27th.
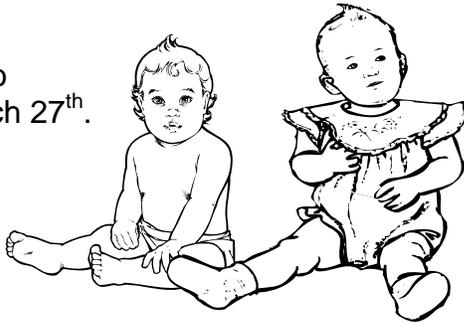
Ms. Barnett is no longer working. There is no income other than $200/month child support.

II. Ms. Barnett can receive LIM for herself and the twins.

Note: **The twins are also eligible for Newborn Medicaid through March of next year and Ms. Barnett is eligible for RSM PgW through May. If the AU becomes ineligible for LIM during this period of time, Medicaid coverage should continue under these COAs.**

Ms. Barnett chooses LIM for herself and the twins. LIM case is approved on April 10th.

Ms. Barnett reports and verifies on October 12th that she will return to work on November 2nd and will earn $900 gross/month. She will receive her first paycheck on November 30th. She still receives $200/month direct child support. Ms. Barnett is ongoing ineligible due to increased earnings. CMD is completed October 12th.

III. TMA is approved initially November through April. The additional 6 months are May through October.

Ms. Barnett complies with all TMA reporting requirements. In October, a CMD is completed to determine if anyone will continue to be eligible for Medicaid.

IV. Effective November, RSM is approved for children only since mother is not pregnant. Earnings $900 + child support $150 ($200-$50) exceed the GIC for three. (LIM ineligible).

Ms. Barnett verifies a raise in earnings to $1200/month gross. She still receives $200/month child support. She reports this on April 27th when the twins are 13 months old.

V.   RSM is continued for the twins. They are still eligible as children 1 – 5.

Ms. Barnett continues to receive RSM for the children and small salary increases for the next four years. In February, before the twins turn 6 years old, a CMD is completed. Ms. Barnett verifies she now earns $1500/month gross wages and continues to receive $200/month child support.

VI.   RSM is discontinued as the children are no longer eligible due to income. CMD options given:

PeachCare for Kids and Medically Needy.

Because Medically Needy uses unpaid medical bills to "spenddown" excessive income to a very low limit, Ms. Barnett chooses not to apply for Medically Needy unless she needs it at some later date. Ms. Barnett is given an application for PeachCare for Kids.

Continuing Medicaid Determination

Ms. Susan Sims receives LIM for herself and her son Seth (8). Also in the home is her boyfriend Sam Dawkins, who is not Seth's father. Ms. Sims is pregnant with Mr. Dawkins' child. Mr. Dawkins has monthly wages of $1100. The household has no other resources or income. The baby, Patrick, is born on September 17th.

Sam Dawkins
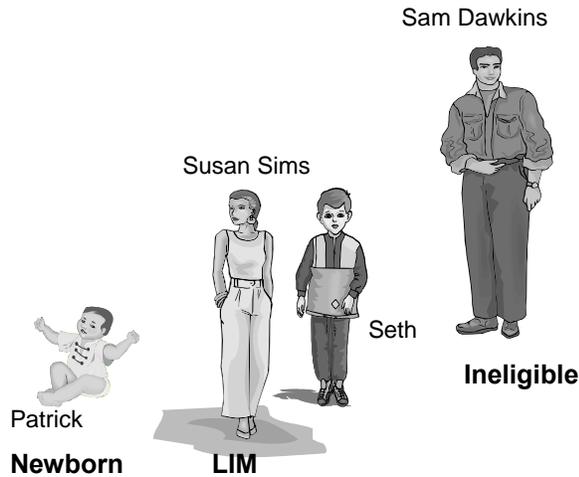
Medicaid

Ms. Sims receives LIM with her son. Note that her boyfriend has no effect on the case. They are not married and do not have a mutual child. At this point, they do not meet the definition of a blended family.

Susan Sims

Seth

Ineligible

Patrick

Newborn   **LIM**

Once Patrick is born the family meets the definition of a blended family. A CMD is completed.

Susan Sims

If LIM is considered for everyone in the family, the AU would be ineligible because of Mr. Dawkins' income. Ms. Sims and Seth remain eligible for LIM and Patrick is eligible for Newborn.

Patrick

Seth

Newborn

LIM
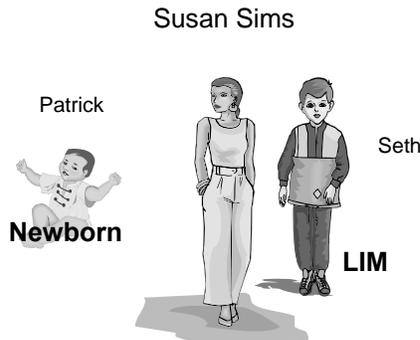
At the end of the Newborn eligibility for Patrick, a CMD is completed. Mr. Dawkins' income would continue to make everyone ineligible for LIM in one AU. If Patrick is excluded from LIM, Mr. Dawkins and his income would also be excluded. Ms. Sims and Seth should remain a LIM AU of two.

Although Patrick has been excluded from LIM, RSM should be considered for him. He would be the RSM AU. Everyone else in the family would be included in the BG:

Patrick, because he is in the AU.

Susan, because she is Patrick's mother.

Seth, because he can be included

Sam, because he is Patrick's father.

And Patrick would be eligible for RSM.

Family Medicaid

Participant Guide

EMERGENCY MEDICAL ASSISTANCE

Objectives

☐   Participants will be able to identify applicants who meet the criteria for Emergency Medical Assistance.

☐   Participants will be familiar with medical treatments that are considered emergency services.

☐   Participants will be able to identify the correct SOP for an application processed through Emergency Medical Assistance.

☐   Participants will be able to identify the appropriate Emergency Medical Assistance coverage period.

☐   Participants will be able to identify the steps to approve an Emergency Medical Assistance application.

☐   Participants will be able to enter basic information on SUCCESS for an EMA application.

Outline

EMA EXAMPLES

Example 1:

Ms. Maria Lena applies for Medicaid April 22, 2007. She delivered her baby, Tony Lena, on April 18, 2007. Ms. Lena is not a U.S. citizen or lawfully admitted qualified alien. Ms. Lena's application Form 94 indicates she does not have any resources or income. Refer to Ms. Lena's DMA-Form 526.

A.   What COA is Ms. Lena potentially eligible for?

B.   What is the SOP for Ms. Lena's application?

C.   Does Ms. Lena meet the basic non-financial criteria required to determine eligibility? If no, what requirements are not met? Can she still potentially receive Medicaid?

D.   What is Ms. Lena's Medicaid coverage period?

E.   If Ms. Lena is approved for Medicaid through EMA, will she automatically receive the 60-day transition coverage?

F.   Is Tony eligible to receive Medicaid?

PHYSICIAN'S STATEMENT
FOR
EMERGENCY MEDICAL ASSISTANCE

Patient's Name: __Maria Lena__   DOB: __02/15/86__

Patient's Address: __1210 Darling Drive__
__Buford, Ga. 30068__

Patient's Telephone #: __404 333-1234__

Individuals who do not meet Medicaid citizenship/alienage requirements may be eligible for
Emergency Medical Assistance (EMA). EMA provides payment for the treatment of emergency
when such care and services are necessary for the treatment of an emergency medical condition
of the alien, provided such care and services are not related to either an organ transplant
procedure or routine prenatal or postpartum care. An emergency is defined as:

"**Acute symptoms**" of sufficient severity (including severe pain) such that the absence of
immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part"

The individual will have to be determined eligible for Emergency Medical Assistance under one
of the Department's existing regular Medicaid coverage groups:

- Aged, blind or disabled;
- Pregnant women;
- Children under 19 years of age; or
- Parents in families with very low income.

This form should be completed and signed by the provider after the Emergency has occurred.
Forms containing future dates of service are invalid.

I provided EMERGENCY medical services on __04/18/07__ through
(Date of onset)
__04/18/07__ for the individual listed above.
(Not to exceed 30 days from condition onset date)

__Southside Health Center__   __Sarah Jones, LPN__
(Provider's Name)   (Provider or Authorized Designee's Signature)

__512 Hillside Street__   __04/19/07__
(Provider's Address)   (Date)

DMA – Form 526 (Revised December 2005)

Notification of Eligibility –
Emergency Medicaid Assistance Program

Important information:

You have applied for Emergency Medicaid Assistance (EMA) benefits. If you are determined to be eligible, you will receive an approval letter which includes your Medicaid certification for the dates Medicaid coverage was granted for the emergency service(s). The dates of certification were determined during the eligibility process from information provided by your attending medical provider. It is important to note that final determination of whether a medical service meets the definition of emergency care is made by the Georgia Medical Care Foundation (GMCF).

Emergency services are those that are:
- Medically necessary, and
- Result from the sudden onset of a health condition with acute symptoms, and
- Which, in the absence of immediate medical attention, are reasonably likely to result in at least one of the following:
  - Placing the individuals health in serious jeopardy, or
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part.

Only services that fully meet the federal definition of an emergency medical condition will be covered beginning January 1, 2006. Not all services that are medically necessary meet this definition. Certain types of care provided to chronically ill persons are beyond the intent of federal law and are not considered emergency services. Such care includes alternate level of care in a hospital, nursing facility services, home care and personal care.

Only emergency services determined to meet the Federal definition of an emergency as determined by GMCF are covered. Any services provided after the emergency condition is stabilized are not payable. Your provider can bill you for services which are not determined to be emergencies.

All the information that I have provided is true and complete as far as I know.

By signing this form below, I acknowledge that I understand that only those claims which meet the Federal definition of an Emergency as determined by the Georgia Medical Care Foundation may be paid by the Medicaid program.

_Maria Lena_____   _4/22/07_____
Signature   Date

Example 2:

Ms. Nona Nuday applies for Medicaid on February 27, 2007. She is pregnant and her EDD is September 20, 2007. Ms. Nuday is not a U.S. citizen or lawfully admitted qualified alien. Ms. Nuday's application indicates she does not have any resources or income. Refer to Ms. Nuday's DMA-Form 526.

A.   What COA is Ms. Nuday potentially eligible for?

B.   What is the SOP for Ms. Nuday's application?

C.   What is Ms. Nuday's Medicaid coverage period?

D.   Is a faxed Form 526 acceptable?

PHYSICIAN'S STATEMENT
FOR
EMERGENCY MEDICAL ASSISTANCE

Patient's Name: _Nona Mudday_   DOB: _07/17/89_

Patient's Address: _10 Palms Street_
Atlanta, Ga. 30303

Patient's Telephone #: _678 123-4567_

Individuals who do not meet Medicaid citizenship/alienage requirements may be eligible for Emergency Medical Assistance (EMA). EMA provides payment for the treatment of emergency when such care and services are necessary for the treatment of an emergency medical condition of the alien, provided such care and services are not related to either an organ transplant procedure or routine prenatal or postpartum care. An emergency is defined as:

"**Acute symptoms**" of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part"

The individual will have to be determined eligible for Emergency Medical Assistance under one of the Department's existing regular Medicaid coverage groups:
- Aged, blind or disabled;
- Pregnant women;
- Children under 19 years of age; or
- Parents in families with very low income.

This form should be completed and signed by the provider after the Emergency has occurred. Forms containing future dates of service are invalid.

I provided EMERGENCY medical services on _02/10/07_   through
_02/25/07_   (Date of onset)
(Not to exceed 30 days from condition onset date)   for the individual listed above.

Grady Health Systems   _Andy Richards, RN/GYN_
(Provider's Name)   (Provider or Authorized Designee's Signature)

80 Jessie Hill Jr. Drive   _02/26/07_
(Provider's Address)   (Date)

DMA – Form 526 (Revised December 2005)

Notification of Eligibility –
Emergency Medicaid Assistance Program

Important information:

You have applied for Emergency Medicaid Assistance (EMA) benefits. If you are determined to be eligible, you will receive an approval letter which includes your Medicaid certification for the dates Medicaid coverage was granted for the emergency service(s). The dates of certification were determined during the eligibility process from information provided by your attending medical provider. It is important to note that final determination of whether a medical service meets the definition of emergency care is made by the Georgia Medical Care Foundation (GMCF).

Emergency services are those that are:
- Medically necessary, and
- Result from the sudden onset of a health condition with acute symptoms, and
- Which, in the absence of immediate medical attention, are reasonably likely to result in at least one of the following:
    o Placing the individuals health in serious jeopardy, or
    o Serious impairment to bodily functions, or
    o Serious dysfunction of any bodily organ or part.

Only services that fully meet the federal definition of an emergency medical condition will be covered beginning January 1, 2006. Not all services that are medically necessary meet this definition. Certain types of care provided to chronically ill persons are beyond the intent of federal law and are not considered emergency services. Such care includes alternate level of care in a hospital, nursing facility services, home care and personal care.

Only emergency services determined to meet the Federal definition of an emergency as determined by GMCF are covered. Any services provided after the emergency condition is stabilized are not payable. Your provider can bill you for services which are not determined to be emergencies.

All the information that I have provided is true and complete as far as I know.

By signing this form below, I acknowledge that I understand that only those claims which meet the Federal definition of an Emergency as determined by the Georgia Medical Care Foundation may be paid by the Medicaid program.

Nora Murday
Signature

February 27, 2007
Date

EMA APPLICATION – INID KRUSCHEV
WALK THROUGH

Background – Ms. Inid Kruschev is pregnant and applies for Medicaid. Her Form 94 and Form 526 were received in the county office on 10/2/06. Attached to her application is a doctor's statement verifying her pregnancy. According to the statement, she is expecting one child on 5/9/07. Her application was screened and registered upon receipt.

You contact Ms. Kruschev by phone to clarify the information provided on her forms. During your conversation with Ms. Kruschev, you discover that she speaks limited English. Therefore, you contact your Limited English Proficiency and Sensory Impairment Coordinator to provide a translator for your interview with Ms. Kruschev. Ms. Kruschev's primary language is Russian.

- Review Ms. Kruschev's forms before beginning her eligibility determination.

- Begin the interview process and stop at the DEM1 screen.

- The trainer will walk through the new material.

INTERVIEW

AMEN

- Select O

ADDR

- Primary language is Russian

- Access NARR to enter documentation

STAT

- Ms. Kruschev is an applicant

- Resides with her mother, Greita Kruschev

- Access ADT to enter documentation

DEM1 – Inid Kruschev

- Enter G in SSA/SSN Appl For field

- Never married

- Lives at home

- Does not receive SSI

- Enter pregnancy data

- Access REMA to enter documentation

DEM2 – Inid Kruschev

- Undocumented alien; verified by AR's statement

- Agrees to cooperate with TPL

- Access ADT to enter documentation

ALAS

- Country of Origin is Russia

```
INTERVIEW                  ALIENS AND STUDENTS - ALAS              ALAS 01
Month 11 06                      0002   10 02 06

 Client Name INID         KRUSCHEV                Client ID XXXXXXXXX
                                      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                          RU



 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     2123
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                  15-lett
```

RES1 – DONE

- Refer to Form 94

PROCESS

AMEN

- Select P

APP1

- Select 10/06

ADDR

- Fastpath to ALAS

ALAS

- Refer to Form 526

- Enter Y in Emergency Medical Indicator

- Enter Emergency Medical Begin and End Dates

- Access REMA to enter documentation

- Fastpath to DONE

```
CHANGE                    ALIENS AND STUDENTS - ALAS              ALAS 01
Month 10 06                      6991   10 05 06

 Client Name INID        KRUSCHEV              Client ID XXXXXXXXX
                                         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                         RU                           Y  10 01 06 10 01 06



 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

              15-lett
```

DONE

- Commit to the database

APP1

- Return to AMEN

FINALIZE

AMEN

- Select Q

APP2

- Press ENTER

ELIG – 10/06

- If correct, confirm the data

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

 AU ID XXXX00192     Prog MA    Prog Type P    Med COA P01
 Confirm Y

  AU     AU Status   AU Stat    Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons     Date       Date    Date      Date    Type  End Date
  A                  100506    100206  100106
 -------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp    Date         Date    Date   Date    T  Date
 INID   KRU   SE OT   Y    RE   A 100506 295  100206  100106  10012006




 Message


```

CAFI – 10/06

- If correct, confirm the data

```
FINALIZE           CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
Month 10 06
 AU ID XXXX00192   Prog MA   Prog Type P       Med COA  P01
                              Net Income Test (cont)
 Resources                         Standard - 30 1/3        .00
   Resource Limit            .00   Dependent Care           .00
   Total Resources           .00   Net Earned Income        .00
 Gross Income Test                 Net Unearned Income      .00
   Gross Income Limit        .00   Deemed Income            .00
   Gross Earned Income       .00   Allocated Income         .00
   Net Unearned Income       .00   Net Income               .00
   Deemed Income             .00   Grant Amount             .00
   Allocated Income          .00   Recoupment Amount        .00
 Total Gross Income          .00   Benefit Amount           .00
 Net Income Test                   Previous Benefit         .00
   Net Income Limit      2200.00   Spenddown Amount
   Gross Earned Income       .00   Medical Expense Amt
   Self Employ Work Exp      .00   Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y   Reasons             Budgeting Method P
 Notice Type 0003           Waive Timely Ntc Period         Notice Override
  Review Begin Date 10 06   Review End Date 99 99            Strat 2
 Message

         13-note
```

ELIG – 11/06

- If correct, confirm the data

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

  AU ID XXXX00192      Prog MA    Prog Type P    Med COA P01
  Confirm Y

   AU    AU Status  AU Stat    Appl    Begin    Pd Thru  ---Penalty---
  Stat    Reasons    Date      Date    Date      Date    Type  End Date
   D    245         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
  INID   KRU   SE OT   Y    RE   D 100506 202  100206




  Message
```

CAFI – 11/06

- If correct, confirm the data

```
FINALIZE              CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
Month 11 06
 AU ID XXXX00192    Prog MA   Prog Type P      Med COA  P01
                              Net Income Test (cont)
 Resources                         Standard - 30 1/3        .00
   Resource Limit         .00    Dependent Care             .00
   Total Resources        .00    Net Earned Income          .00
 Gross Income Test                Net Unearned Income        .00
   Gross Income Limit     .00    Deemed Income              .00
   Gross Earned Income    .00    Allocated Income           .00
   Net Unearned Income    .00    Net Income                 .00
   Deemed Income          .00    Grant Amount               .00
   Allocated Income       .00    Recoupment Amount          .00
 Total Gross Income       .00    Benefit Amount             .00
 Net Income Test                  Previous Benefit           .00
   Net Income Limit       .00    Spenddown Amount
   Gross Earned Income    .00    Medical Expense Amt
   Self Employ Work Exp   .00    Net Spenddown Amt
 Bnft Eff Date 100506  Bnft Confirm Y   Reasons 245         Budgeting Method
 Notice Type 0005          Waive Timely Ntc Period           Notice Override
  Review Begin Date 10 06   Review End Date 11 06             Strat
 Message

  13-note
```

APP2

- Finalize the application

Congratulations!
You have just completed an EMA application.

EMA APPLICATION – ELAINE D'AGOSTINO
INDEPENDENT STUDY

Background – Ms. Elaine D'Agostino is pregnant and applies for Medicaid. Her Form 94 and Form 526 were received in the county on 10/5/06. Attached to her application is a doctor's statement verifying her pregnancy. The doctor's statement confirms she is pregnant with one child and her EDD is 1/12/07. Her application was screened and registered upon receipt.

A telephone call to Ms. D'Agostino confirms that she is not married, lives alone and does not have any income or any resources. She states she does not have any TPL, but agrees to cooperate with TPL. Ms. D'Agostino is an undocumented alien from Mexico. Though she is bilingual, she would like to receive her notices in Spanish.

- Review Ms. D'Agostino's forms before beginning her eligibility determination.

- During the interview process, correct her ethnicity code by pressing PF16 to access CRS and update the demographic data.

- Process and finalize her application.

Family Medicaid

Participant Guide

REVIEWS

Objectives

☐ Participants will be able to identify which Family Medicaid Classes of Assistance require reviews.

☐ Participants will be able to identify the time frames in which reviews are due.

☐ Participants will be able to identify the time frame for completing reviews.

☐ Participants will be able to identify forms to be completed at review.

☐ Participants will be able to determine the points of eligibility that are to be verified at review.

☐ Participants will be able to process Family Medicaid Reviews in SUCCESS

☐ Participants will be able to incorporate good interviewing skills in a Review interview

Outline

I.   Introduction (MR 2700 and 2706)

II.   Family Medicaid Reviews (MR 2706)

III.   Forms Required at Reviews (MR 2706)

IV.   Verification at Reviews (MR 2051, 2200, 2300 and 2400)

V.   Budgeting at Reviews (MR 2650, 2653 and 2655)

VI.   SUCCESS

VII.   Alexis Daniel Walk Through SUCCESS Case

VIII.   Notification (MR 2701)

IX.   Review Real Play SUCCESS Cases

X.   Jane Simmons Capstone SUCCESS Case

ALTERNATE REVIEW PROCESS
(MR 2706)

Step 1	Mail the alternate review form to the AU no less than 10 days prior to the date the completed form is due to be returned.
Step 2	Mail any other required forms.
Step 3	Review the returned review form for all points of eligibility. Contact the AU if the review form is not returned, if it is incomplete or unsigned, or if additional information or verification is required. Contact may be made by telephone or by mail. A system-generated notice that a review form was not returned is considered sufficient contact. **NOTE:** The review may be processed without a signature or completed review form if all other required information is obtained by other measures.
Step 4	Complete Clearinghouse requirements.
Step 5	Document the information obtained during the review process.
Step 6	Upon completion of the review and, if applicable, the receipt of any additional information or verification requested, finalize the review.
Step 7	Notify the AU of the review disposition.

DISPOSITION OF THE MEDICAID REVIEW

Procedures for Disposition of the Medicaid Review	
IF	**THEN**
the AU complies with all requirements	continue eligibility, if appropriate.
the AU misses a scheduled appointment	contact the AU to obtain required information. This contact may be made by mail and/or by telephone. **NOTE:** A standard (FTF) review is not required for **ANY** Medicaid COA. A Medicaid case may **not** be terminated for failure to appear for a standard review.
the agency did not provide written notice of the appointment 10 days prior to the appointment date and the appointment is missed	contact the AU to obtain required information. This contact may be made by mail and/or by telephone. **NOTE:** A standard (FTF) review is not required for **ANY** Medicaid COA. A Medicaid case may **not** be terminated for failure to appear for a standard review.
the AU fails to provide requested verification	determine if Medicaid eligibility for any other COA can be established without the requested verification. If so, continue eligibility under the new COA. If not, send timely notice and close the Medicaid case following expiration of the timely notice period.
the AU fails to return the Alternate Review Form	contact the AU to obtain required information. A system-generated notice that a review was not returned is considered sufficient contact. **NOTE:** The review may be processed without a signature or completed review form if all other required information is obtained by other measures.
the review is overdue	complete an alternate review.
the case is transferred from another county	complete an alternate review within 30 days of accepting transfer.

FAMILY MEDICAID REVIEW PROCESS

A**.**   SUCCESS selects cases for review at the beginning of the month prior to the Review End Date.

B.   A face-to-face interview is not required for Family Medicaid Reviews.

    1.   Counties may opt to conduct Standard Reviews.

    2.   If a county opts for a Standard Review and the A/R misses the appointment, the case cannot be terminated solely due to the missed appointment.

C.   For Alternate reviews, SUCCESS sends a notice with a mail-in review form the month prior to the review end month and sends the Case Manager an alert.

    1.   Be sure to code the next review field on the MISC screen to send an alternate mail-in review.

    2.   When the form is returned, the Case Manager must initiate the review in SUCCESS and enter the data.

    3.   If the review is not initiated by the 6th day of the review month, SUCCESS sends an alert to the Case Manager and will send a warning notice of closure to the AU.

    4.   If the mail-in review does not have adequate information, the Case Manager should try to obtain the information by phone. Follow up with Form 95 or Form 173 if you do not speak with the customer during the call and/or you need verification.

    5.   When the Case Manager completes the review on SUCCESS, the next review should be coded as an Alternate Review on MISC.

    6.   The review SOP is the last work day of the month in which the review is due.

ALEXIS DANIEL
REVIEW WALK THROUGH

Background – Ms. Daniel is a single mother and lives with her child, Carmen. Ms. Daniel has arrived for her Medicaid review appointment.

She recently moved, but states that her situation is essentially the same as it was when she first applied for Medicaid for Carmen. She continues to work at Coca Cola Enterprises and earns approximately $160.00/week. She has a checking account at Wachovia with a balance of $212.00. She also reports cash of $47.00 and still owns her '95 Honda Accord, valued at $750.00.

Ms. Daniel states that Carmen has been approved for RSDI benefits since her father passed away a few months ago. Additionally, Carmen now goes to ABCD Daycare Center after school. Ms. Daniel pays $30.00/week for this after-school care. She provides a statement from the provider.

Thoroughly document Ms. Daniel's circumstances while completing her review interview.

- Review the Form 222 prior to beginning the review interview.

- Locate Ms. Daniel's client ID number.

- Initiate Ms. Daniel's review.

- Use the data provided to document Ms. Daniel's circumstances and complete her review.

- The trainer will walk through this process.

LOCATE CLIENT ID

AMEN

- Select B

- Enter AU ID #

STAT

- Press ENTER

MISC

- Write down Client ID #

- Press F3

INITIATE REVIEW

AMEN

- Select N

- Remove AU ID number

- Enter Client ID number

REDE

- Enter interview date in Recert Appl Date field

- Enter Y in Sel field next to the case

- Press ENTER

```
UPDATE                      INITIATE REVIEW – REDE                    REDE
Month 11 06                                                           01

Recert Appl Date  10 05 06  Delay Rsn
Sel    F Name   MI        L Name    AU ID           Prog    Review Process
                                                            Begin Date

 Y    ALEXIS             DANIEL    XXXX00016        MA




Message
```

CONDUCT REVIEW INTERVIEW

AMEN

- Select R

- Press ENTER

ADDR

- Review address to ensure accuracy

- Write down the old address

- Enter the new address in the appropriate fields

- Press F21 to access NARR

NARR

- Enter documentation regarding Ms. Daniel's current circumstances

- Press ENTER

ADDR

- Enter Y in the Previous Addresses field

- Press F4 to bypass warning message

PREV

- Enter previous address in the appropriate fields

- Resided at this address from July 2005 until September 2006

- Did not own the property

- Press ENTER

STAT

- Enter documentation regarding AU/BG composition

- Press ENTER

DEM1 01

- Review data to ensure accuracy

- Press ENTER

DEM2 01

- Review data to ensure accuracy

- Form 216 signed 4/4/06 in case record

- Press ENTER

DEM1 02

- Review data to ensure accuracy

- Press ENTER

DEM2 02

- Review data to ensure accuracy

- Carmen is a full-time student and has completed 1st grade

- Provide Health Check brochure

- Enter documentation

- Press ENTER

ALAS 02

- Carmen attends Freedom Elementary school

RES1 01

- Update Ms. Daniel's resources

- Enter documentation

- Press ENTER

RES2 01

- Review data to ensure accuracy

- Update Ms. Daniel's resources

- Enter documentation

- Press ENTER

RES3 01

- Review data to ensure accuracy

- Press ENTER

TRAN 01

- Review data to ensure accuracy

- Press ENTER

RES1 02

- Review data to ensure accuracy

- Press ENTER

RES2 02

- Review data to ensure accuracy

- Press ENTER

RES3 02

- Review data to ensure accuracy

- Press ENTER

TRAN 02

- Review data to ensure accuracy

- Press ENTER

ERN1 01

- Review data to ensure accuracy

- Enter documentation

- Press ENTER

ERN2 01

- Review check stubs provided by Ms. Daniel

- Update data to reflect current situation

- Enter documentation

- Press ENTER

CARE 01

- Update data to reflect current situation

- Enter documentation

- Press ENTER

ERN1 02

- Review data to ensure accuracy

- Press ENTER

ERN2 02

- Review data to ensure accuracy

- Press ENTER

CARE 02

- Review data to ensure accuracy

- Press ENTER

UINC 01

- Review data to ensure accuracy

- Press ENTER

UINC 02

- Update data to reflect current situation

- Enter documentation

- Press ENTER

MISC

- Enter N in Review Complete field

- Enter A in Next Review field

- Press ENTER

```
INTERVIEW           AU NON-FINANCIAL MISCELLANEOUS - MISC         MISC    B
Month 11 06                    6991   10 05 06

 HOH Name ALEXIS        DANIEL                     Client ID XXXX00015
 AU ID XXXX00016     Prog FS

 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                      Delay  QMB  RSM
 Compl  Mand Last Reasgn  Remain                          Rsn    Ovr  Elig
        Std  Type  Ovr    Amount                                      Ovr
   N           A      N
 Sched Interview          QC Penalty End Date
 Del     Unit Number 179602    Inquiry Date 10 05 06      Load ID XXXX
     Next Review A              Appt Date 03 27 06      Appt Type REV
     Appt Begin Time (HH:MM) 07 : 00
     Appt End Time (HH:MM)  07 : 29          Appt Letter Print Location B
     L Name/Appt Remarks  REVIEW AUTO SCHEDULED ON 03/01/06



 Message

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

ELIG A

- Confirm data if accurate

- Press ENTER

```
 CHANGE              NON-FINANCIAL ELIGIBILITY RESULTS - ELIG       ELIG    A
 Month 11 06                    0002   10 01 05                        01

  AU ID XXXX00016     Prog MA    Prog Type F    Med COA F22
  Confirm Y

  AU    AU Status  AU Stat   Appl    Begin    Pd Thru  ---Penalty---
  Stat   Reasons    Date     Date    Date     Date     Type  End Date
  A                100105   100105  100105
 ------------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl   Begin  Pd Thru Penalty
 Name   Name        Incl Resp   Date          Date   Date   Date   T Date
 ALEXIS DAN   SE OT   Y    RP    A 100105 220  100105 100105
 CARMEN DAN   CH OT   Y    RE    A 100105      100105 100105



 Message
```

CAFI A

- Confirm data if accurate

- Press ENTER

```
CHANGE              CASH/MA FINANCIAL ELIGIBILITY - CAFI          CAFI    A
Month 11 06
AU ID XXXX00016   Prog MA   Prog Type F       Med COA  F22
                             Net Income Test (cont)
 Resources                      Standard - 30 1/3      90.00
   Resource Limit          .00  Dependent Care        129.99
   Total Resources         .00  Net Earned Income     646.67
 Gross Income Test              Net Unearned Income    165.00
   Gross Income Limit      .00  Deemed Income            .00
   Gross Earned Income  866.66  Allocated Income         .00
   Net Unearned Income  165.00  Net Income            812.00
   Deemed Income           .00  Grant Amount             .00
   Allocated Income        .00  Recoupment Amount        .00
 Total Gross Income     1031.66  Benefit Amount          .00
 Net Income Test                Previous Benefit         .00
   Net Income Limit     1100.00  Spenddown Amount
   Gross Earned Income   866.66  Medical Expense Amt
   Self Employ Work Exp     .00  Net Spenddown Amt
 Bnft Eff Date 100105  Bnft Confirm Y   Reasons 308 303 306   Budgeting Method P
 Notice Type 0034          Waive Timely Ntc Period          Notice Override
  Review Begin Date 11 06   Review End Date 11 06           Strat 1

Message

  13-note
```

DONE

- Access NARR to update documentation

- Commit data to the database

COMPLETE REVIEW

AMEN

- Select R

- Press ENTER

ADDR

- Press F21 to access NARR

NARR

- Enter documentation regarding receipt of verification

- Press ENTER

ADDR

- Fastpath to ERN2 to enter verification

- Press F4 to bypass warning message

ERN2   01

- Press PF9 to update documentation

- Update data to reflect current situation

- Fastpath to UINC

UINC 02

- Update data to reflect current situation

- Enter documentation

- Press ENTER

MISC

- Enter Y in Review Complete field

- Press ENTER

```
 INTERVIEW              AU NON-FINANCIAL MISCELLANEOUS - MISC         MISC    B
 Month 11 06                        6991   10 05 06

  HOH Name ALEXIS        DANIEL                      Client ID XXXX00015
  AU ID XXXX00016    Prog FS

  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                      Delay  QMB  RSM
  Compl Mand  Last   Reasgn   Remain                         Rsn   Ovr  Elig
        Std   Type    Ovr     Amount                                    Ovr
    Y          A       N
  Sched Interview          QC Penalty End Date
  Del     Unit Number 179602    Inquiry Date 10 05 06      Load ID XXXX
      Next Review A          Appt Date 03 27 06      Appt Type REV
      Appt Begin Time (HH:MM) 07 : 00
      Appt End Time (HH:MM)  07 : 29        Appt Letter Print Location B
      L Name/Appt Remarks  REVIEW AUTO SCHEDULED ON 03/01/06



  Message

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

ELIG A

- Confirm data if accurate

```
CHANGE              NON-FINANCIAL ELIGIBILITY RESULTS - ELIG        ELIG    A
Month 11 06                     0002   10 01 05                         01

 AU ID XXXX00016    Prog MA    Prog Type F   Med COA F22
 Confirm Y

  AU    AU Status  AU Stat   Appl    Begin    Pd Thru  ---Penalty---
 Stat    Reasons    Date     Date    Date      Date    Type  End Date
  A                 100105   100105  100105
 --------------------------------------------------------------------------
 First  Last  Rel V  Mand Finl  --Stat-- Rsn   Appl    Begin  Pd Thru  Penalty
 Name   Name         Incl Resp   Date          Date    Date   Date     T Date
 ALEXIS DAN   SE OT   Y    RP   A 100105 220  100105  100105
 CARMEN DAN   CH OT   Y    RE   A 100105       100105  100105




 Message
```

CAFI A

- Confirm data if accurate

- Confirm Review End Date

```
CHANGE              CASH/MA FINANCIAL ELIGIBILITY - CAFI           CAFI    A
Month 11 06
AU ID XXXX00016   Prog MA   Prog Type F        Med COA  F22
                             Net Income Test (cont)
 Resources                   Standard - 30 1/3       90.00
   Resource Limit      .00   Dependent Care         129.99
   Total Resources     .00   Net Earned Income      646.67
 Gross Income Test           Net Unearned Income    165.00
   Gross Income Limit  .00   Deemed Income             .00
   Gross Earned Income 866.66 Allocated Income         .00
   Net Unearned Income 165.00 Net Income            812.00
   Deemed Income       .00   Grant Amount             .00
   Allocated Income    .00   Recoupment Amount        .00
 Total Gross Income   1031.66 Benefit Amount          .00
 Net Income Test             Previous Benefit         .00
   Net Income Limit  1100.00 Spenddown Amount
   Gross Earned Income 866.66 Medical Expense Amt
   Self Employ Work Exp .00   Net Spenddown Amt
 Bnft Eff Date 100105 Bnft Confirm Y  Reasons 308 303 306  Budgeting Method P
 Notice Type 0034         Waive Timely Ntc Period        Notice Override
  Review Begin Date 11 06   Review End Date 04 07        Strat 1

 Message

  13-note
```

Congratulations!!
You've completed a Medicaid Review!

SANDRA LANGFORD – REVIEW REAL PLAY
FAMILY MEDICAID ONLY

CASE MANAGER SCENARIO

Background – Ms. Sandra Langford is available to conduct her Family Medicaid review on 10/5/06. Conduct Ms. Langford's review.

- Locate Ms. Langford's AU/Client ID numbers on the Alpha list.

- Talk with Ms. Langford up front to establish a rapport and get an overview of her situation.

- Initiate her review and then go through all of the SUCCESS screens to update her information.

- Review all required forms with Ms. Langford and obtain her signature.

- Review the Clearinghouse screens to determine if there are any discrepancies.

- Georgia Data Broker and Vital Records screens have been accessed and viewed; no discrepancies noted.

- The Work Number is accessed to verify her wages. Her wages are verified as:

10/2/06	$81.23	9/1/06	$82.13
9/25/06	$79.58	9/11/06	$77.06

- The value of Ms. Langford's car is $900.00 as verified by NADA.

- Request any needed verification prior to completing her review.

- Once verification is received, complete the review on the MISC screen.

```
                           DOL   WAGE   INQUIRY - WGEI                    WGEI
Next SSN                                                                        01
SSN  312 45 XXXX        Benefit Year Begin Date
Sel   Employer Name     Emplr Num          Qtr/Yr       Wages    Sur
      GARDEN RIDGE       05649689           3  06         960     LAN
      GARDEN RIDGE       05649689           2  06         878     LAN
```

Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total
4/05		1/06		2/06	878	3/06	960

```
Tot  Wages     1,838  Potential Amount     62     Num of  Wks   20    Max  Amt
Message

13-Bendex  14-SDX1            16-UCBI
```

```
INQUIRY       DOL   UNEMPLOMENT INSURANCE PAYMENT HISTORY - UCBI
                                                                           01
Next  SSN                                      Mailing  Address (UCCA)
SSN  312  45  XXXX  Month/Yr          and   13  Months  Prior
SUR     Ben  Yr  Begin      WBA    MBA      Weeks Dur 19  Clm VALID
               Monthly  Totals         Totals for last 10 weeks          EUC  Eff  Date
Month/Year     Paid    # of Checks          Check  Date          Amount  Paid
   10/06
   09/06
   08/06
   07/06
   06/06
   05/06
   04/06
   03/06
   02/06
   01/06
   12/05
   11/05
   10/05

Message

13 – BNDX     14 – SDXI     15 – WGEI
```

```
INQUIRY                    BENDEX INQUIRY – BNDX                        BNDX
NEXT SSN                                                                 01
Claimant Name SANDRA    LANGFORD        DOB 05 15 76      SEX  F
County                                  Beneficiary's own SSN  312 45 XXXX
SSA Claim Number                        Claimant SSN
Agency Code         110                 Category of Assistance
      State Control Data                Old BIC        Payment Status
Mo. Benefit Payable    .00              Date of Initial Entitlement
Gross Amount Payable  .00               Date of Current Entitlement
Net Monthly Amount    .00               Communication Code    MAT
Black Lung Acct. No. 00000000           Prev Gross Amt      Date
BL Entit/Term Date 00 00 BL Status      SSI Entit/Term Dt      Status
BL Payment Amount  0.00                 Monthly Overpymt Deducted     0.00
RR Claim No   RR Status                 End Date Overpayment       00.00
SMI Option Code          Date Entitled  H.I. Option Code E  Amt      0.00
SMI Premium Amt          Date Term  00 00  H.I. Date Entit/Term
SMI Premium Payer
SMI 3rd Party DT Entit/Term     00 00   Disab Onset 00 00   Direct Dep
Dual Entit SSN          000 00 000      Trip Entit SSN        000 00 0000


Message
0020   INQUIRY COMPLETED SUCCESSFULLY
   14 – sdx    15 – wgei       16 – ucbi
```

```
INQUIRY              STATE DATA  EXCHANGE - SDX1                    SDX1
NEXT SSN                                                             01
Client  Name  SANDRA            LANGFORD            Client  ID
      DOB 05 15 1976      Race B        Individual SSN 312 45 XXXX
Date of              Mrtl  Alien  Es. Pers.  --SDX Transaction--  Multiple
Death      Sex  Sts   Code   Ind        Code    Date        SSN

  Appl   Denial      Denial   Appeal   Appeal  Onset Disab/  SSI Elig  Medicd
  Date   Date        Code     Date     Code     Blindness     Date     Test

Chg Dt   Pay Stat   Fed Liv  State/Cnty
                                   FS     FS    FS Input   TPL   Medicd
                                   Appl   Stat  Date       Cd    Eff Dt




                                   ---- STATE  SUPPLEMENT ----
Adv  Pay  Bdgt Mo. SSI/GPA Mthly Asst    Amt   Pd  Elig  Pd   Grant

------------------ OVERPAYMENT -----------------  --------------- RESOURCES -----------
Ind    Balance  Waiver Amt  Waiver Date   House   MV  Lfe Ins  Prop

Message
```

DONNA NEILSON – REVIEW REAL PLAY
FAMILY MEDICAID ONLY

CASE MANAGER SCENARIO

Background – Ms. Donna Neilson is available for her Family Medicaid review on 10/5/06. Conduct Ms. Neilson's review.

- Locate Ms. Neilson's AU/Client ID numbers on the Alpha list.

- Talk with Ms. Neilson up front to establish a rapport and get an overview of her situation.

- Initiate her review and then go through all of the SUCCESS screens to update her information.

- Review all required forms with Ms. Neilson and obtain her signature.

- Review Clearinghouse screens to determine if there are any discrepancies.

- Georgia Data Broker and Vital Records screens are viewed; no discrepancies.

- The value of Ms. Neilson's car is $500.00 as verified by NADA.

- Request any needed verification prior to completing her review.

- Once verification is received, complete the review on the MISC screen.

```
                              DOL   WAGE    INQUIRY - WGEI                    WGEI
Next SSN                                                                           01
SSN   321  01  XXXX    Benefit Year Begin Date
Sel    Employer  Name            Emplr  Num          Qtr/Yr      Wages    Sur
        BROOME'S SELF            02356476            2  06        1,545    NEI
        WENDY'S                  05965114            2  05          794    NEI
```

Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total
3/05		4/05		1/06		2/06	1,545

```
Tot  Wages      1,545   Potential Amount          Num of  Wks       Max  Amt
Message

13-Bendex  14-SDX1            16-UCBI
```

```
INQUIRY        DOL    UNEMPLOMENT  INSURANCE  PAYMENT  HISTORY - UCBI
                                                                              01
Next  SSN                                      Mailing  Address  (UCCA)
SSN   321  01  XXXX  Month/Yr            and   13  Months  Prior
SUR      Ben  Yr  Begin      WBA      MBA      Weeks  Dur    Clm  VALID
             Monthly  Totals         Totals  for last  10  weeks         EUC  Eff  Date
Month/Year      Paid    # of Checks          Check  Date          Amount  Paid
     10/06
     09/06
     08/06
     07/06
     06/06
     05/06
     04/06
     03/06
     02/06
     01/06
     12/05
     11/05
     10/05

Message

13 – BNDX      14 – SDXI      15 – WGEI
```

```
INQUIRY                    BENDEX INQUIRY – BNDX                          BNDX
NEXT SSN                                                                   01
Claimant  Name  DONNA      NEILSON            DOB 06 02 82      SEX  F
County                                        Beneficiary's own SSN    321 01 XXXX
SSA  Claim  Number                            Claimant  SSN
Agency  Code          110                     Category  of  Assistance
         State Control Data                   Old BIC          Payment  Status
Mo. Benefit  Payable                          Date of Initial Entitlement
Gross Amount Payable                          Date of Current Entitlement
Net Monthly Amount                            Communication Code    MAT
Black Lung Acct. No. 00000000                 Prev  Gross Amt           Date
BL  Entit/Term  Date  00  00  BL Status       SSI Entit/Term Dt            Status
BL  Payment  Amount                           Monthly  Overpymt  Deducted
RR  Claim No   RR  Status                     End  Date  Overpayment
SMI  Option  Code            Date Entitled    H.I.  Option  Code      Amt
SMI  Premium  Amt            Date Term        H.I.  Date  Entit/Term


SMI  Premium  Payer
SMI  3ʳᵈ  Party  DT  Entit/Term      00  00   Disab  Onset 00 00    Direct Dep
Dual  Entit  SSN           000  00  000       Trip  Entit  SSN        000  00  0000

Message
0020   INQUIRY COMPLETED SUCCESSFULLY
   14 – sdx     15 – wgei       16 – ucbi
```

```
INQUIRY                STATE DATA  EXCHANGE - SDX1                        SDX1
NEXT  SSN                                                                  01
Client   Name  DONNA           NEILSON                    Client   ID
       DOB  06  02  1982       Race         Individual SSN 321  01  XXXX
Date  of               Mrtl   Alien   Es.  Pers.  --SDX Transaction--   Multiple
  Death       Sex  Sts   Code    Ind              Code      Date        SSN

  Appl    Denial       Denial   Appeal     Appeal    Onset Disab/   SSI Elig  Medicd
  Date    Date         Code     Date       Code       Blindness      Date     Test

Chg Dt   Pay Stat   Fed Liv   State/Cnty
                                          FS     FS    FS Input    TPL    Medicd
                                          Appl   Stat  Date        Cd     Eff Dt


                                       ---- STATE  SUPPLEMENT ----
Adv  Pay  Bdgt Mo.  SSI/GPA Mthly Asst    Amt  Pd  Elig  Pd   Grant

------------------ OVERPAYMENT ----------------   -------------- RESOURCES ----------
Ind    Balance  Waiver Amt  Waiver  Date         House   MV  Lfe Ins  Prop


Message
```

HERMAN HORTON – REVIEW REAL PLAY
FAMILY MEDICAID & FOOD STAMPS

CASE MANAGER SCENARIO

Background – Mr. Herman Horton is available for his review on 10/5/06. His Food Stamp review is due in 10/06. His RSM review is due in 1/07. Conduct both reviews.

- Locate Mr. Horton's AU/Client ID numbers on the Alpha list.

- Talk with Mr. Horton up front to establish a rapport and get an overview of his situation.

- Initiate both reviews and then go through all of the SUCCESS screens to update his information.

- Review all required forms with Mr. Horton and obtain his signature.

- Review the Clearinghouse screens to determine if there are any discrepancies.

- Vital Records screens are viewed; no discrepancies noted.

- The value of Mr. Horton's car is $3300 as verified by NADA.

- Request any needed verification prior to completing his reviews.

- Once verification is received, complete the reviews on the MISC screen and update the Review End Dates so that future reviews will occur within the same month.

```
                            DOL   WAGE   INQUIRY - WGEI                    WGEI
Next SSN                                                                        01
SSN  554 01  XXXX    Benefit Year Begin Date
Sel    Employer  Name          Emplr  Num        Qtr/Yr       Wages    Sur
       RHODES FURN             46568798          3  06         1,445    HOR
       RHODES FURN             46568798          2  06         1,212    HOR
       RHODES FURN             46568798          1  06           989    HOR
       RHODES FURN             46568798          4  05         1,325    HOR
```

```
Qtr/Yr  Qtr-Total      Qtr/Yr  Qtr-Total      Qtr/Yr  Qtr-Total      Qtr/Yr  Qtr-Total
 4/05    1,325          1/06     989            2/06    1,212          3/06    1,445

Tot Wages     4,971   Potential Amount      94     Num of Wks  20     Max  Amt
Message

13-Bendex  14-SDX1           16-UCBI
```

```
INQUIRY       DOL    UNEMPLOMENT  INSURANCE  PAYMENT  HISTORY - UCBI
                                                                              01
Next SSN                                          Mailing  Address  (UCCA)
SSN  554 01  XXXX  Month/Yr           and   13  Months  Prior
SUR     Ben Yr Begin       WBA      MBA       Weeks Dur    Clm VALID
             Monthly  Totals          Totals for last 10  weeks            EUC Eff Date
Month/Year    Paid    # of Checks            Check  Date            Amount  Paid
     10/06
     09/06
     08/06
     07/06
     06/06
     05/06
     04/06
     03/06
     02/06
     01/06
     12/05
     11/05
     10/05

Message

13 – BNDX     14 – SDXI      15 – WGEI
```

```
INQUIRY                    BENDEX INQUIRY – BNDX                          BNDX
NEXT SSN                                                                    01
Claimant  Name  HERMAN        HORTON        DOB              SEX  M
County                                       Beneficiary's own SSN  554 01 XXXX
SSA  Claim  Number                           Claimant SSN
Agency  Code           110                   Category of Assistance
        State Control Data                   Old BIC        Payment  Status
Mo. Benefit  Payable                         Date of Initial Entitlement
Gross Amount Payable                         Date of Current Entitlement
Net Monthly Amount                           Communication Code    MAT
Black Lung Acct. No. 00000000                Prev  Gross Amt           Date
BL  Entit/Term  Date  00  00  BL Status      SSI Entit/Term Dt         Status
BL  Payment  Amount                          Monthly  Overpymt  Deducted
RR  Claim No   RR  Status                     End  Date  Overpayment
SMI  Option Code           Date Entitled     H.I.  Option  Code      Amt
SMI  Premium  Amt          Date Term         H.I.  Date  Entit/Term

SMI  Premium  Payer
SMI  3rd  Party  DT Entit/Term    00  00     Disab  Onset 00  00    Direct Dep
Dual  Entit  SSN          000  00  000       Trip  Entit  SSN       000  00  0000

Message
0020   INQUIRY COMPLETED SUCCESSFULLY
   14 – sdx    15 – wgei      16 – ucbi
```

```
INQUIRY               STATE DATA  EXCHANGE - SDX1                        SDX1
NEXT SSN                                                                    01
Client  Name  HERMAN              HORTON                   Client  ID
       DOB              Race              Individual SSN 554 01 XXXX
Date of              Mrtl   Alien  Es. Pers.  --SDX Transaction--   Multiple
  Death     Sex  Sts   Code   Ind          Code      Date         SSN

  Appl  Denial      Denial   Appeal    Appeal   Onset Disab/   SSI Elig  Medicd
  Date  Date        Code     Date      Code     Blindness      Date      Test

Chg Dt   Pay Stat   Fed Liv  State/Cnty
                                        FS     FS    FS Input   TPL    Medicd
                                        Appl   Stat  Date       Cd     Eff Dt


                                        ---- STATE  SUPPLEMENT ----
Adv  Pay  Bdgt Mo.  SSI/GPA Mthly Asst    Amt  Pd  Elig  Pd   Grant

----------------- OVERPAYMENT ----------------   -------------- RESOURCES -----------
Ind   Balance  Waiver Amt  Waiver Date    House   MV  Lfe Ins  Prop


Message
```

MITCHELL GREEN – REVIEW REAL PLAY
FAMILY MEDICAID & FOOD STAMPS

CASE MANAGER SCENARIO

Background – Mr. Mitchell Green is available for his review on 10/5/06. His Food Stamp review is due in 10/06. His RSM review is due in 1/07. Conduct both reviews.

- Locate Mr. Green's AU/Client ID numbers on the Alpha list.

- Talk with Mr. Green up front to establish a rapport and get an overview of his situation.

- Initiate both reviews and then go through all of the SUCCESS screens to update his information.

- Review all required forms with Mr. Green and obtain his signature.

- Review the Clearinghouse screens to determine if there are any discrepancies.

- Vital Records screens are viewed; no discrepancies noted.

- The value of Mr. Green's car is $2300 as verified by NADA.

- Request any needed verification prior to completing his reviews.

- Once verification is received, complete the reviews on the MISC screen and update the Review End Dates so that future reviews will occur within the same month.

```
                        DOL   WAGE   INQUIRY - WGEI              WGEI
Next SSN                                                                01
SSN  553 01  XXXX   Benefit Year Begin Date
Sel   Employer Name        Emplr  Num        Qtr/Yr      Wages     Sur
      LISTONS MARK         32156789          3  06       1,260     GRE
      LISTONS MARK         32156789          2  06       1,008     GRE
      LISTONS MARK         32156789          1  06       1,304     GRE
      LISTONS MARK         32156789          4  05       1,325     GRE
```

```
Qtr/Yr  Qtr-Total      Qtr/Yr  Qtr-Total      Qtr/Yr  Qtr-Total      Qtr/Yr  Qtr-Total
 4/05    1,325          1/06    1,304          2/06     1,008         3/06     1,260

Tot Wages     4,897   Potential Amount    94    Num of Wks   20    Max Amt
Message

13-Bendex 14-SDX1          16-UCBI
```

```
INQUIRY       DOL   UNEMPLOMENT INSURANCE PAYMENT HISTORY - UCBI
                                                                       01
Next SSN                                        Mailing Address (UCCA)
SSN  553  01  XXXX  Month/Yr          and   13  Months Prior
SUR      Ben Yr Begin      WBA    MBA     Weeks Dur   Clm VALID
           Monthly Totals       Totals for last 10 weeks       EUC Eff Date
Month/Year    Paid    # of Checks        Check Date        Amount Paid
    10/06
    09/06
    08/06
    07/06
    06/06
    05/06
    04/06
    03/06
    02/06
    01/06
    12/05
    11/05
    10/05

Message

13 – BNDX    14 – SDXI    15 – WGEI
```

```
INQUIRY                BENDEX INQUIRY – BNDX                    BNDX
NEXT SSN                                                        01
Claimant Name MITCHELL    GREEN        DOB              SEX  M
County                                 Beneficiary's own SSN  553 01 XXXX
SSA Claim Number                       Claimant SSN
Agency Code         110                Category of Assistance
        State Control Data             Old BIC      Payment Status
Mo. Benefit Payable                    Date of Initial Entitlement
Gross Amount Payable                   Date of Current Entitlement
Net Monthly Amount                     Communication Code   MAT
Black Lung Acct. No. 00000000          Prev Gross Amt          Date
BL Entit/Term Date 00 00 BL Status     SSI Entit/Term Dt        Status
BL Payment Amount                      Monthly Overpymt Deducted
RR Claim No   RR Status                End Date Overpayment
SMI Option Code         Date Entitled  H.I. Option Code     Amt
SMI Premium Amt         Date Term      H.I. Date Entit/Term


SMI Premium Payer
SMI 3rd Party DT Entit/Term    00 00   Disab Onset 00 00   Direct Dep
Dual Entit SSN         000 00 000      Trip Entit SSN      000 00 0000

Message
0020   INQUIRY COMPLETED SUCCESSFULLY
   14 – sdx    15 – wgei       16 – ucbi
```

```
INQUIRY              STATE DATA  EXCHANGE - SDX1                SDX1
NEXT SSN                                                        01
Client Name MITCHELL         GREEN           Client ID
       DOB          Race              Individual SSN 553 01 XXXX
Date of          Mrtl  Alien  Es. Pers. --SDX Transaction--  Multiple
 Death    Sex  Sts  Code   Ind       Code    Date           SSN

 Appl  Denial      Denial  Appeal    Appeal  Onset Disab/  SSI Elig  Medicd
 Date  Date        Code    Date      Code    Blindness     Date      Test

Chg Dt  Pay Stat   Fed Liv  State/Cnty
                                   FS    FS    FS Input   TPL   Medicd
                                   Appl  Stat  Date       Cd    Eff Dt


                                   ---- STATE SUPPLEMENT ----
Adv Pay Bdgt Mo. SSI/GPA Mthly Asst   Amt  Pd  Elig  Pd   Grant

------------------ OVERPAYMENT ----------------   --------------- RESOURCES -----------
Ind    Balance Waiver Amt  Waiver Date    House   MV  Lfe Ins  Prop

Message
```

```
                            DOL   WAGE   INQUIRY - WGEI                    WGEI
Next SSN                                                                        01
SSN  553 02 XXXX   Benefit Year Begin Date
Sel   Employer Name          Emplr Num          Qtr/Yr       Wages     Sur
       DOTS FASHION          89413565           3  06        2,700     GRE
       CATO FASHION          56132132           4  05        3,568     GRE
```

Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total
4/05	3,568	1/06		2/06		3/06	2,700

```
Tot Wages    6,268   Potential Amount    168    Num of Wks   19    Max Amt
Message

13-Bendex 14-SDX1          16-UCBI
```

```
INQUIRY        DOL    UNEMPLOMENT INSURANCE  PAYMENT  HISTORY - UCBI
                                                                        01
Next SSN                                       Mailing Address (UCCA)
SSN  553 02 XXXX Month/Yr 01/06      and   13 Months Prior
SUR      Ben Yr Begin 01/05/06    WBA  168 MBA 3192    Weeks Dur    Clm VALID
              Monthly Totals          Totals for last 10 weeks          EUC Eff Date
Month/Year    Paid    # of Checks          Check Date          Amount Paid
    10/06
    09/06
    08/06
    07/06
    06/06
    05/06     672      4
    04/06     672      4
    03/06     840      5
    02/06     672      4
    01/06     336      2
    12/05
    11/05
    10/05

Message

13 – BNDX     14 – SDXI     15 – WGEI
```

```
INQUIRY                 BENDEX INQUIRY – BNDX                        BNDX
NEXT SSN                                                              01
Claimant  Name  SUSAN       GREEN       DOB              SEX  F
County                                      Beneficiary's own SSN   553 02 XXXX
SSA  Claim  Number                          Claimant  SSN
Agency  Code        110                      Category  of  Assistance
        State Control Data                   Old BIC        Payment  Status
Mo. Benefit  Payable                         Date of Initial Entitlement
Gross Amount Payable                         Date of Current Entitlement
Net Monthly Amount                           Communication Code    MAT
Black Lung Acct. No. 00000000               Prev  Gross Amt            Date
BL Entit/Term  Date 00 00 BL Status         SSI Entit/Term Dt         Status
BL  Payment  Amount                          Monthly  Overpymt  Deducted
RR  Claim No   RR  Status                    End  Date  Overpayment
SMI  Option  Code         Date  Entitled    H.I.  Option  Code      Amt
SMI  Premium  Amt         Date  Term        H.I.  Date  Entit/Term
SMI  Premium  Payer
SMI  3rd Party  DT  Entit/Term       00 00   Disab  Onset 00 00    Direct Dep
Dual  Entit  SSN        000 00 000           Trip  Entit  SSN       000 00 0000

Message
0020    INQUIRY COMPLETED SUCCESSFULLY
    14 – sdx    15 – wgei        16 – ucbi
```

```
INQUIRY              STATE DATA  EXCHANGE - SDX1                    SDX1
NEXT SSN                                                              01
Client  Name  SUSAN         GREEN          Client  ID
        DOB                 Race           Individual  SSN 553  02 XXXX
Date  of        Mrtl  Alien  Es.  Pers.    --SDX Transaction--     Multiple
  Death    Sex  Sts   Code   Ind            Code     Date          SSN

  Appl  Denial      Denial   Appeal    Appeal   Onset Disab/   SSI Elig  Medicd
  Date  Date        Code     Date      Code     Blindness      Date      Test

Chg Dt   Pay Stat    Fed Liv  State/Cnty
                                           FS     FS    FS Input   TPL    Medicd
                                           Appl   Stat  Date       Cd     Eff Dt


                                           ---- STATE  SUPPLEMENT ----
Adv  Pay  Bdgt Mo.  SSI/GPA Mthly Asst       Amt   Pd   Elig  Pd   Grant

----------------- OVERPAYMENT ---------------   -------------- RESOURCES ----------
Ind    Balance  Waiver  Amt  Waiver  Date   House    MV   Lfe Ins  Prop


Message
```

CapStone Exercise

JANE SIMMONS

A few months ago, Ms. Simmons and her two children, Tina and Richard, were approved for Medicaid. It is now time for a review of the family's circumstances to determine ongoing eligibility.

Your office received her Medicaid Review form on 10/1/06. You contact Ms. Simmons by telephone on 10/5/06 to complete a review of her family's circumstances based on the information provided. Document all appropriate screens and provide the most comprehensive coverage available.

BACKGROUND

Ms. Simmons receives Low Income Medicaid for herself and her two children. Ms. Simmons agrees to sign and return any required forms.

RESIDENCE

212 Riverside Parkway, Apt. 6C
Macon, Georgia 31210-4858
(478) 4581187
Bibb County
Lived at previous address from 11/05 – 8/06
Did not own the property at the previous address

DEMOGRAPHICS

Jane Simmons:
SSN 325-01-XXXX
DOB 6/2/82
Never married
Lives at home
Does not receive SSI
U.S. Citizen; verified by birth certificate on file
Identity verified by GA Driver's License
Agrees to cooperate with TPL
Has no other health insurance

Tina Simmons:
SSN 325-02-XXXX
DOB 3/19/00
Lives at home
Does not receive SSI
Father is Kenneth Baker, deceased
U.S. Citizen; verified by birth certificate on file
Identity verified by Declaration of Citizenship form dated 5/1/06
2nd grade student at Oakdale Elementary

Richard Simmons:
SSN 325-03-XXXX
DOB 10/25/04
Lives at home
Does not receive SSI
Father is Lawrence Johnson
U.S. Citizen; verified by birth certificate on file
Identity verified by Declaration of Citizenship form dated 5/1/06

ABSENT PARENTS

Lawrence Johnson:
Acknowledged, natural father of Richard
Lives at 123 Thomas Drive, Macon, GA 31808
Phone number is 478-291-6700
Never married to Ms. Simmons
DOB 5/15/80; 26 years old
Born in Macon, GA
African American, black hair, brown eyes
6 feet 2 inches tall
Weighs approximately 200 pounds
Employed as a painter since January 1995
Works for Wallace Management on Barnett Street, Macon, GA
Not court ordered to pay child support

Kenneth Baker:
Deceased
Putative, natural father of Tina
Address unknown
Never married to Ms. Simmons
DOB is unknown; 32 years old
Born in Macon, GA
African American, black hair, brown eyes
6 feet tall
Weighs approximately 180 pounds
Employer unknown
Not court ordered to pay child support

RESOURCES

Ms. Simmons reports cash of $35.00 and a checking account at
Washington Mutual with balance of $112.00. Ms. Simmons still owns her
2000 Toyota Corolla used for employment. The car is valued at $4125
according to NADA; she owes nothing on the car.

INCOME

Ms. Simmons states her family has three sources of income. She continues to work at Brooks Self Storage on 367 Lakeside Dr., in Macon, GA. The phone number is 478-466-3211. She started working there on 9/1/05 and received her first check on 9/8/05. Ms. Simmons continues to work an average of 15-20 hours per week; paid on Mondays as verified by her check stubs. Her rate of pay increased with the enactment of the federal minimum wage to $7.25 per hour. Ms. Simmons states that all checks are representative of her usual earnings. Clearinghouse screens viewed; no discrepancies noted.

Pay End Date	Pay Received Date	Amount	Verification
9/5/06	9/7/06	121.25	CH
9/12/06	9/14/06	138.92	CH
9/19/06	9/21/06	126.45	CH
9/26/06	9/28/06	130.83	CH

Ms. Simmons also receives direct child support payments for Richard. His father, Lawrence Johnson, pays $100/month on the first of each month. Ms. Simmons provides a statement from Mr. Johnson verifying this information.

Ms. Simmons further states that Tina was recently approved for RSDI survivor's benefits due to the death of her father, Kenneth Baker. Tina now receives $76.00 each month. She began receiving this amount on 10/1/06. Ms. Simmons provides the award letter from the Social Security Administration verifying this information.

DEPENDENT CARE

Ms. Simmons states that she no longer pays child care costs because her former neighbor, Ms. Annie Neal, has agreed to take care of both children at no cost to Ms. Simmons. Ms. Neal continues to reside at 562 Charter Boulevard; phone number is 478-623-5689.

Family Medicaid

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

> Where can I find more practice or additional help that I can do on my own?

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!!!

Family Medicaid

Participant Guide

FORM

TABLE OF CONTENTS

▲ A Spanish version of this form is also available.

Family Medicaid

Participant Guide

REFERENCE

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SUCCESS FAMILY MEDICAID COA CODES

NEWBORN	**F15**
LIM	**F01**
TMA	**F07**
4 MONTHS CS	**F09**
RSM Pg	**P01**
RSM Child	**F22**
MEDICALLY NEEDY CHILD	**F99**
MEDICALLY NEEDY PGW	**P99**
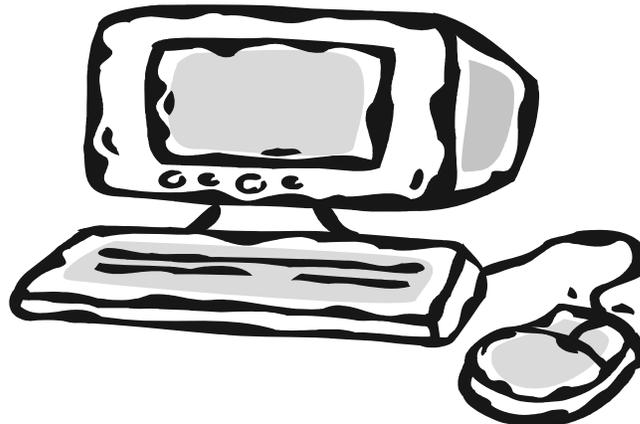
OVERVIEW OF NON-FINANCIAL AND FINANCIAL ELIGIBILITY REQUIREMENTS FOR FAMILY MEDICAID COAs
(Note: Only the Medicaid COAs covered in this training are listed)

Class of Assistance (COA)	Age	Application for Other Benefits	CIT/Alien	OCSS**	Enumeration	Living with Specified Relative	Residency	TPR	Resources	Income	6 Month Reviews	Special Reviews
Newborn (F15)	0-13 months (through month of first birthday)	No	Yes	No	No	No	Yes	No	No	No	No	No
LIM (F01)	Yes (child<18) ♦	Yes: except SSI & TANF	Yes	Yes, unless child-only case	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes ▲
TMA (F07)	Yes (child<18) ♦	No	Yes	No	No, if requirements met under LIM	Yes	Yes	Yes	No	Yes, TMA limits	No	Quarterly
4 Months Child Support (F09)	Yes (child<18) ♦	Yes: except SSI & TANF	Yes	No	No, if requirements met under LIM	Yes	Yes	Yes	No	No	No	Yes ▲
RSM Child (F22)	Yes (child<19) ♦	Yes, except SSI & TANF	Yes	Yes, unless child-only case	Yes	No	Yes	Yes	No	Yes, RSM limits	Yes	Yes ▲
RSM PG (P01)	No	No	Yes	No	Yes	No	Yes	Yes	No	Yes, RSM limits	No	Yes ●

♦ Eligibility for a Medicaid COA ends at the end of the month in which the child reaches the age limit for that COA.
Referrals **are not required for non-custodial parents who are providing medical coverage or for child-only Family Medicaid cases.

▲ Special reviews are completed as needed
● Special review is completed the month prior to the expected date of delivery and monthly thereafter until termination of pregnancy

R-3

FAMILY MEDICAID PENALTIES!

CRITERION	LIM	RSM
Failure to comply with:	**Penalty applies to:**	**Penalty applies to:**
Enumeration	Individual, if no good cause • If parent fails to comply, the parent is penalized. • If an adult fails to comply for a child, the child is excluded from the AU.	Individual • If parent fails to comply, the parent is penalized. • If an adult fails to comply for a child, the child is excluded from the AU, but may be in the BG.
Citizenship/Alienage	Individual • If parent fails to comply, the parent is penalized. • If an adult fails to comply for a child, exclude the child from the AU.	Individual • If parent fails to comply, the parent is penalized. • If an adult fails to comply for a child, exclude the child from the AU, but may be in the BG.
Child Support	Parent • A child is neither penalized nor excluded for an adult's failure to cooperate. • Pregnant women are not required to cooperate for the unborn child.	No penalty applied • A child is neither penalized nor excluded for an adult's failure to cooperate. • Pregnant women are not required to cooperate for the unborn child.
Third Party Resources	Parent/Both parents if included in the AU • A child is neither penalized nor excluded for an adult's failure to cooperate.	Parent/Both parents if included in the AU/BG • A child is neither penalized nor excluded for an adult's failure to cooperate.
Application for Other Benefits	• If the benefit is for the parent, exclude all AU members. • If the benefit is for a child, exclude only the child. • Pregnant women receiving Medicaid under any COA, except RSM-PgW, are not required to apply for UCB if in 2nd or 3rd trimester.	• If the benefit is for the parent, exclude all AU members. • If the benefit is for a child, exclude only the child from the AU. The child may be included in the BG at AR's option. • Pregnant women receiving under RSM-PgW are not required to comply.

FAMILY MEDICAID 2009 FINANCIAL LIMITS
INCOME LIMITS

BUDGET GROUP (BG) SIZE	LIM GROSS INCOME CEILING (GIC)	LIM STANDARD OF NEED (SON)	PCK 235% FEDERAL POVERTY LEVEL (FPL)	RSM PgW, NB 200% FEDERAL POVERTY LEVEL (FPL)	RSM CHILD 0-1 TMA, WIC 185% FEDERAL POVERTY LEVEL (FPL)	RSM CHILD 1-5 133% FEDERAL POVERTY LEVEL (FPL)	RSM CHILD 6-19 100% FEDERAL POVERTY LEVEL (FPL)	FM-MNIL FAMILY MEDICAID MNIL
1	$435	$235	$2,123	$1,805	$1,670	$1,201	$903	$208
2	$659	$356	$2,856	$2,429	$2,247	$1,615	$1,215	$317
3	$784	$424	$3,587	$3,052	$2,823	$2,030	$1,526	$375
4	$925	$500	$4,320	$3,675	$3,400	$2,444	$1,838	$442
5	$1,060	$573	$5,053	$4,299	$3,976	$2,859	$2,150	$508
6	$1,149	$621	$5,784	$4,922	$4,553	$3,273	$2,461	$550
7	$1,243	$672	$6,517	$5,545	$5,130	$3,688	$2,773	$600
8	$1,319	$713	$7,250	$6,169	$5,706	$4,102	$3,085	$633
9	$1,389	$751	$7,984	$6,793	$6,284	$4,517	$3,397	$667
10	$1,487	$804	$8,718	$7,417	$6,862	$4,932	$3,709	$708
11	$1,591	$860	$9,452	$8,041	$7,440	$5,347	$4,021	$758
12	$1,635	$884	$10,186	$8,665	$8,018	$5,762	$4,333	$808
(+) PER ADDITIONAL BG MEMBER	$44	$24	$734	$624	$578	$415	$312	$50

RESOURCE LIMITS

LIM RESOURCE LIMIT: $1000   FM-MN ALLOWABLE MILEAGE REIMBURSEMENT 50.5 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT
NUMBER OF INDIVIDUALS IN FM-MN BG

1	2	3	4	5	6	7	8	9	10	11	12
$2,000	$4,000	$4,100	$4,200	$4,300	$4,400	$4,500	$4,600	$4,700	$4,800	$4,900	$5,000

APPENDIX A.2   FAMILY MEDICAID 2006 (effective 02/01/2006)
2006 INCOME LIMITS

	LIM	LIM	PCK	RSM PgW NB	RSM CHILD 0-1 TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	GROSS INCOME CEILING (GIC)	STANDARD OF NEED (SON)	235% FEDERAL POVERTY LEVEL	200% FEDERAL POVERTY LEVEL (FPL)	185 % FEDERAL POVERTY LEVEL (FPL)	133% FEDERAL POVERTY LEVEL (FPL)	100 % FEDERAL POVERTY LEVEL (FPL)	FAMILY MEDICAID MNIL
1	$ 435	235	1920	1634	1511	1087	817	208
2	659	356	2585	2200	2035	1463	1100	317
3	784	424	3252	2767	2560	1840	1384	375
4	925	500	3917	3334	3084	2217	1667	442
5	1060	573	4583	3900	3608	2594	1950	508
6	1149	621	5250	4467	4132	2971	2234	550
7	1243	672	5915	5034	4656	3348	2517	600
8	1319	713	6580	5600	5180	3724	2800	633
9	1389	751	7248	6168	5706	4102	3084	667
10	1487	804	7916	6736	6232	4480	3368	708
11	1591	860	8584	7304	6758	4858	3652	758
12	1635	884	9252	7872	7284	5236	3936	808
(+) PER ADDITION AL BG MEMBER	44	24	668	568	526	378	284	50

2006 RESOURCE LIMITS

LIM RESOURCE LIMIT $1000	FM-MN ALLOWABLE MILEAGE REIMBURSEMENT 44.5 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT NUMBER OF INDIVIDUALS IN FM-MN BG											
1	2	3	4	5	6	7	8	9	10	11	12
$ 2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

(02/20/06)

Georgia Health Partnership
  Multi Heath Net...866-211-0950
    www.ghp.georgia.gov ....770-570-3373 Atlanta

Health Check Provider 866-211-0950
                                 ....770-570-3373 Atlanta

Health Management Systems.........................770-937-0180 Fax
  5660 New Northside Drive, Suite 750
  Atlanta, GA 30328

Online Policy Manual
  www.odis.dhr.state.ga.us

Voicemail Service
  www.gavoicemail.com

Women, Infants and Children Program...................800-228-9173

DOCUMENTATION

Documentation is an important element in determining the accuracy of a case. 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.

TWO TYPES:

AUTOMATED DOCUMENTATION TOOLS (ADTS)

FREE-FORM DOCUMENTATION

Documentation is also required when the following codes are used:

TC – Telephone Call: document 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: document source of verification.

LE – Letter: document who sent the letter and the date.

MAIN MENU

▪ Press the Tilde key to access the Automated Documentation Tool (ADT)

```
               ************************************
           **   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 "?"
```

ADT

▪ Enter First Initial, Last Name, Caseload ID, County and phone number

ADDR

Access REMA to enter documentation

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

CO 049 LO 049 Load ID 1001  Client ID XXXX00269  RES CO
HOH F Name KATHERINE        MI      Name NORWOOD                 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
        879              CHARTER             BLVD
City MACON              ST GA   Zip 31201       Phone 478 854 7811


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
1881 STREET NUMBER OR BOX NUMBER NOT FOUND ON STREET
            15-lett                          21-narr  23-alau  24-del
```

Include the following:

- Questionable mailing address

- Directions to the A/R's home, if needed

NARR

For all case actions – application, review or change

Accessible from ADDR and DONE only

```
UPDATE                      NARRATIVE - NARR                    NARR
                                                                  01

   10/05/2006 03:55 PM Family Medicaid Training 555-555-5555




                                                                 More
  MESSAGE
      13-bott
```

Include the following:

- Type and date of contact and/or action being taken

- Initial conversation with AR prior to beginning the interview

- Name of person spoken to and that the person is the best source of information

- Type of interview (face-to-face, alternate or telephone)

- Need for prior months and action taken

- HIPAA and/or EMA Notification forms and action taken

- Date and type of SUCCESS letter; include Load ID and name of Case Manager

- Date and type of information indicated on verification checklist

STAT

Access ADT to enter documentation

```
UPDATE                      REMARKS - REMA                    REMA
                                                               00
  ***************************** MEDICAID STAT *****************************
  10/05/2006 12:25 PM Family Medicaid Training 555-555-5555
  LIST OTHER   NAME                    RELAT      AGE     FIN RES {Y/N}
  HH MEMBERS   :_____   :_____  :_____   :_____
  NOT  INCL    :_____   :_____  :_____   :_____
  IN THE AU    :_____   :_____  :_____   :_____
  INELIGIBLE/PENALIZED AU MEMBER? Y/N ( ) IF YES, EXPLAIN:_____
  :_____
  EXPLAIN STEP PARENT SITUATION:_____
  TRACE RELATIONSHIPS AND DOCUMENT FINANCIAL RESPONSIBILITY:
  :_____
  LIM ELIGIBLE? Y/N ( ) IF NO, EXPLAIN:_____
  CMD, AS NEEDED:_____
  DUAL ELIG AU MEMBER(S)/COA? EXPLAIN:_____
  3MP COVERAGE RQSTD.? Y/N( ) IF YES, MO. AND DETERMINATION FOR EA.:_____
  :_____
  CROSS REF AU#s FOR 3MP AND ONGOING:_____
  EXPLAIN USE OF 500 DENIAL CODE:_____
                                                               More
 MESSAGE
 0019 UPDATE COMPLETED SUCCESSFULLY
 13-bott
```

Include the following:

- Name, age and relationship of non-AU members and why they are not included in the AU

- Unusual and/or financial responsibilities

- Denial/closure codes entered by Case Manager

- Circumstances and outcome of completing a CMD

- Dual eligibility for more than one COA

- Trace the relationship of the non-parent grantee relative to the children in the AU

- For retroactive months – list months and eligibility determination

- Never acceptable to document client states no change

- Best practice – document any referrals made for closed/denied cases

- For Newborn living with a female caretaker – document the following:

  This child is Newborn eligible. This child is the (grandchild, niece, nephew, etc.) of the head of household. Due to system limitations, it is not possible to code the relationship correctly.

- For Newborn living with a male caretaker – document the following:

  The child in this case is Newborn eligible. Due to system limitations, it is not possible for this child to be in an F15 case because he/she lives with a male caretaker. This child is eligible through the month in which he/she turns 1. The 6 month review will be completed as a dummy review.

```
UPDATE                         REMARKS - REMA                     REMA
                                                                    01
 ****************************** ADD/DEL MEM *****************************
 10/05/2006 09:49 AM Family Medicaid Training 555-555-5555
         Adding  ( )                          Deleting  ( )
  :_____     :_____
  :_____     :_____
 Date of report: _____      Timely Report?  Y/N ( )
 Person Reporting:_____
 Date moved in:_____
 Is the Person(s) who moved in currently receiving benefits?  Y/N ( )
 If yes, where: _____
 Relationship to SE?:_____
 If paternal relative, was paternity verified? Y/N ( )  Verified by:_____
  :_____
  :_____
 Date moved out: _____
 Moved out, where did they move?:_____
  :

                                                               More

 MESSAGE

 13-bott
```

Include the following:

- Changes in AU composition (addition and deletion of AU members)

- Circumstances and outcome of completing a CMD

- Dual eligibility for more than one COA

```
UPDATE                     REMARKS - REMA                      REMA
                                                                00
  ************************* STAT TERMINATION/DENIAL *************************
  10/05/2006 09:50 AM Family Medicaid Training 555-555-5555
  ( )APPL ( )TIMELY REV ( )UNTIMELY REV ( )CHANGE
  REASON FOR TERMINATION/DENIAL =
    ( )AU FAILED TO PROVIDE REQUIRED INFORMATION AS FOLLOWS;
       DATE F-173 GIVEN/MAILED:_____ DUE DATE:_____
  INFORMATION REQUESTED:_____
  Referrals made:_____
  EIS Eligible Y/N ( )  12 month period before reapplying:_____ to :_____
  TSS Eligible Y/N ( )  Eligible from :_____ to :_____
  WSP Eligible Y/N ( )  Eligible from :_____ to :_____
  TFP Eligible Y/N ( )  Eligible from :_____ to :_____
  Amount of Frozen FS benefits:_____




                                                                        More
  MESSAGE
  0019 UPDATE COMPLETED SUCCESSFULLY
  13-bott
```

Include the following:

- Denial/closure codes entered by the Case Manager

- Circumstances and outcome of completing a CMD

- Best Practice: Document any referrals made for closed/denied cases

```
UPDATE                      REMARKS - REMA                      REMA
                                                                 00
   ***************************** Fair Hearing *****************************
   10/05/2006 12:26 PM Family Medicaid Training 555-555-5555
   AU ID - 173500211  Case Type - MA
   Date of request for hearing:_____
   Reason for hearing:_____
   :_____
   :_____
   Date hearing request sent to Legal Services:_____
   Date hearing scheduled:_____   Hearing rescheduled    Yes ( )  No ( )
   Date of decision:_____
   Decision in favor of Agency ( )    Reason - Withdrawal ( )
                                               No show    ( )
                                               Other      ( ) Explain:_____
   :_____
   Decision in favor of Client ( )      Explain:_____
   :_____
   Benefits Continued  Yes ( )   No ( )      Claim scheduled   Yes ( )   No ( )
   Comments:_____
                                                                More
 MESSAGE
 0019 UPDATE COMPLETED SUCCESSFULLY
 13-bott
```

Include the following:

- Fair hearing request date

- Follow-up and outcome of hearing decision

DEM1

Access REMA to enter documentation

```
                          CLIENT DEMOGRAPHIC 1 - DEM1                DEM1 01
Month 11 06                        0002   06 01 06

Client Name                                 Suf      Client ID

Alt    SSA/SSN   SSN Appl      SSN1    V   More          DOB      V Sex Race Eth
Name   Appl For    Date                   SSNs      (MM DD YYYY)



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



  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




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

Include the following:

- Details of any enumeration penalty imposed

- Details of deprivation and CSS referral code

- Unusual circumstances regarding Georgia residency

- How pregnancy was verified

- If pregnancy was terminated for any reason other than a live birth

- Form 138 and action taken

DEM2

Access ADT to enter documentation

```
UPDATE                      REMARKS - REMA                     REMA
                                                                 01
   ****************** Health Insurance/Citizenship/Identity ******************
   10/05/2006 09:51 AM Family Medicaid Training 555-555-5555
   Does A/R have health insurance or other TPL {trust,e.g.}?  Y/N ( )
   If yes, date form 285 sent to DMA:_____
   Assignment of TPL rights completed? Y/N ( )
   Signed form DMA 285 in the record, if necessary? Y/N ( )

   Customer was informed about Health Check by
   Face to Face( ) Telephone( ) Mailed Brochure( )

   Citizenship verified by:_____
   :_____
   Identity verified by: _____
   :_____
   Declaration of citizenship in record dated:_____

   FS only - Citizenship Good cause waiver granted due to:_____
   :_____
                                                                    More
 MESSAGE

 13-bott
```

Include the following:

- Citizenship verification or alien status to include the type of evidence used

    - If based on receipt of Medicare or SSI, include dates of receipt of SSI and method of verification

- Identity verification if citizenship is not verified from first tier

- Declaration of Citizenship for ALL AU members on DEM2 01

- Declaration of Citizenship form and action taken

- Availability of TPL and/or details of non-cooperation for TPL

- DMA 285 form and action taken

- HIPP referral, if applicable

- Health Check referral for ALL AU members on DEM2 01

- Details of any disability/incapacity codes

- Details and resolution of any Death Match interface

ALAS

Access REMA to enter documentation

```
                        ALIENS AND STUDENTS - ALAS                ALAS 01
Month 11 06                       0002   10 02 06

 Client Name                                 Client ID
                                         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



 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     2123
 0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
                15-lett
```

Include the following:

- Details of Form 526 for EMA

- Forty (40) qualifying hours for aliens

APID

Access REMA to enter documentation

```
                    ABSENT PARENT IDENTIFICATION - APID        APID    A
Month 11 06                  7691    02 01 06                       01 More


 HOH Name                                     Del AP    AP Returned Home
  AP Name                                          Suf
     SSN              Seq Num   00001

 Dep First Last Legal Pat  Dep First Last Legal Pat  Dep First Last Legal Pat
     Name Name  Rel  Type      Name Name  Rel  Type      Name Name  Rel  Type




 IV-D  --- Good Cause Claim ---   Referral   130 Form    UCB    Other Income
 Coop  Ind Rsn Stat   Date         Date       Date       Ind       Types

 Union/Local                                                    More APs


 Message 0013
```

Include the following:

- Non-cooperation with CSS

- Good cause for failure to cooperate

- Changes and discrepancies in AP information

  - Date of Form 713 sent to CSS via email

- SUCCESS Form 130 date and Load ID

- Explanation if AP is unknown

- Details if AP provides health insurance for children and no CSS referral is made

  - Enter NOT APPLICABLE in AP name field

APAD

Access REMA to enter documentation

```
                    ABSENT PARENT ADDRESS - APAD            APAD    A
Month 11 06                                                   01

 HOH Name                                  Client ID
  AP Name                                  SSN

 Curr Addr Line 1                    Line 2
 City                         ST      Zip           Phone
 Date at Address

 Prev Addr Line 1                  Line 2
 City                        ST     Zip          Phone
 Date at Address

 AP's Father                                       Delete
 Street                   City                     ST    Zip

 AP's Mother                                       Delete
 Maiden
 Street                   City                     ST    Zip


 Message
```

Include the following:

- Changes and date Form 713 sent to CSS via email

APDE

Access REMA to enter documentation

```
                    ABSENT PARENT DEMOGRAPHIC - APDE        APDE    A
Month 11 06                                                  01

 HOH Name                                 Client ID
 AP Name                                  SSN

 --------- Marital Information ---------   Rel HOH   Drvr Lic   License Plate
 Stat   Date           City        ST     To AP       ST       ST   Number


    DOB        Approx  ---- Birth Place ----   Sex  Race  Hgt   Hair   Eye  Wgt
 (MM DD YYYY)  Age        City        ST                  Inches Color Color Lbs


 -------------------------- Military Information ---------------------------
 Stat   ID Num    Branch  Entry Dt   Exit Dt     Allotment Pay   Allotment Recip


 -------------------------- Incarceration Information ----------------------
  Cd   Release Dt Sentence Lgth  Min Confine           Institution
               Yr      Mo       Yr    Mo
 Message

                15-lett    20-next ap
```

Include the following:

- Changes and date Form 713 sent to CSS via email

APEM

Access REMA to enter documentation

```
                    ABSENT PARENT EMPLOYMENT - APEM            APEM    A
 Month 11 06                                                   01

  HOH Name                                     Client ID
  AP Name                                      SSN

  Primary Employer    Delete        Occupation
  Name                              Empl Date
  Address Line 1                    Line 2
  City                       ST    Zip          Phone

  Secondary Employer  Delete        Occupation
  Name                              Empl Date (MM YY)
  Address Line 1                    Line 2
  City                       ST    Zip          Phone

  Former Employer     Delete        Occupation
  Name                              Empl Date (MM YY)
  Address Line 1                    Line 2
  City                       ST    Zip          Phone




  Message
```

Include the following:

- Changes and date Form 713 sent to CSS via email

APCO

Access REMA to enter documentation

```
                    ABSENT PARENT COURT ORDER - APCO          APCO     A
   Month 11 06

 HOH Name                                  Client ID
  AP Name                                   SSN

  Order        Support       Support    Freq    Payee          Docket
  Date         Obligation    Arrears            Code           Number




  Paying       Date of      Last Pymnt      Agency Receiving Payment
  Support      Last Pymnt    Amount




 Message
              15-lett    20-next ap
```

Include the following:

- Changes and date of Form 713 sent to CSS via email

RES1

Access REMA to enter documentation

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

Client Name                                 Client ID

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
```

Include the following:

- Unusual activity involving resources and countable value if amount is not readily apparent

- Conversion or disposition of resources at review or change

RES2

Access REMA to enter documentation

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

Client Name                              Client ID

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


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 0013
0013 REQUIRED FIELDS ARE IDENTIFIED BY "?"
             15-lett                                    23-alau   24-del
```

Include the following:

- Vehicle use if Use code is not self explanatory

- Joint ownership

- Good faith efforts to sell

- Bankruptcy

- Conversion or disposition of resources at review or change

RES3

Access REMA to enter documentation

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

Client Name                                   Client ID

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




Message

   15-lett                           24-del
```

Include the following:

- Details of any listed resource

- Conversion or disposition of resources at review or change

ERN1

Access ADT to enter documentation

```
UPDATE                        REMARKS - REMA                      REMA
                                                                  01
   ****************************** ERN1 History ******************************
   10/05/2006 12:31 PM Family Medicaid Training 555-555-5555
   EMPLOYER:_____
   BEGIN DATE: _____   END DATE:_____   Timely? Y/N ( )
     REASON FOR TERMINATION:_____
     HOW WAS THE TERMINATION VERIFIED:_____
     SHOULD VOLUNTARY QUIT SANCTION BE APPLIED? Y/N ( )
     EXPLAIN:_____

   ACTUAL MONTHS OF 30 & 1/3 FOR TANF:_____
                             MAO:_____
    :_____
   DOL Hit? Y/N ( )
   DISCREPANCIES? Y/N ( ) Resolution of discrepancies:_____
    :_____
    :_____


                                                               More
    MESSAGE

    13-bott
```

Include the following:

- Current employment record to track employer's name, begin/end dates, reason for termination and how verified

- Copy and paste DOL information that appears for AU members 16 or older (press tilde key and the info will copy and paste to the ERN1 REMA)

- Discrepancies in Clearinghouse information

- Months of $30 & 1/3

ERN2

Access ADT to enter documentation

```
UPDATE                    REMARKS - REMA                         REMA
                                                                  01
  ******************************* ERN2 CAL *******************************
  10/05/2006 12:31 PM Family Medicaid Training 555-555-5555
  App( )  Review( )  New Job ( )  Rate Of Pay ( )  Hrs Chg ( )
  Date of change:_____ Date of Report:_____ Timely( ) Untimely( )
  If new employment, Rate of pay/hours:_____
  EMPLOYER:_____
    Date Pd     Gross     Tips      Verf     Rep{Y/N}
  1:_____    (       ) (       ):_____  ( )
  2:_____    (       ) (       ):_____  ( )
  3:_____    (       ) (       ):_____  ( )
  4:_____    (       ) (       ):_____  ( )
  5:_____    (       ) (       ):_____  ( )
  6:_____    (       ) (       ):_____  ( )
     Total     :_____ /:_____ = :_____ Rep Pay
  If not Rep, explain:_____
  Freq of pay  WK( )  BIWK( )  SEMIMTH( ) MONTHLY( ) ACTUAL( )
  Hr Rate:_____
  CALCULATE Y/N ( )    Cal Monthly Income:_____
                                                              More
 MESSAGE

 13-bott
```

Include the following:

- Hourly rate of pay

- Tips, if not included in gross pay

- Reason any pay period is not considered to be representative

- Why actual income used in budgeting

- Type of verification used

- Calculation and frequency of pay

```
UPDATE                           REMARKS - REMA                       REMA
                                                                       01
   ******************************* YTDCAL *********************************
   10/05/2006 12:31 PM Family Medicaid Training 555-555-5555
   Worksheet {if needed}
   Determine a missing check amount based on Year to Date

   Gross YTD from the check
   of:_____ after the missing check;          (              )
                                        Minus
   Gross current amount from
   check after missing check;                     (              )
                                        Minus
   Gross YTD from the check
   of:_____ before the missing check;         (              )
                                        Equals
   CALCULATE Y/N ( )
   Amount of missing check;                       (              )


                                                              More
 MESSAGE

 13-bott
```

Include the following:

- Verification used to determine amount of missing check

```
UPDATE                           REMARKS - REMA                       REMA
                                                                       01
   ****************************** ERN2 EVNC ******************************
   10/05/2006 12:31 PM Family Medicaid Training 555-555-5555
   App( )  Review( )  Hourly Rate:_____

   Client states the pay periods listed on EVNC are representative of
   expected pay with the following exceptions:_____
   :_____
   :_____
   Does AU member receive tips that are not included in the gross pay?

   Y/N ( )    If yes, explain:_____
   :_____
   :
                                                              More
 MESSAGE

 13-bott
```

Include the following:

- Reason any pay period is not considered to be representative

```
UPDATE                        REMARKS - REMA                    REMA
                                                                01
  ************************* ERN2 SELF EMPLOYMENT *************************
  10/05/2006 12:32 PM Family Medicaid Training 555-555-5555
  App( )  Review( )  New Job( )  Rate Of Pay( )  Hrs Chg( )
  Date of change:_____ Date of Report:_____ Timely( ) Untimely( )
  Rate of pay/hrs/frequency: _____Type of SE: _____
  Does AR incur any expense related to the SE? Y(  )  N(   ) Explain:_____
  :_____
  AR chose ( )Actual Verified Expenses - See case record for verified expenses
          ( )40% Standard - Expense verified :_____ See case record
  Document verification and calculation of Gross SE income:_____
  :_____
  :_____
  :_____
  Calculation of Pay listed on ERN2 was determined as follows:_____
  Gross SE $(        ) - actual expenses $(        ) = Countable FS SE $(        )
      OR
  Gross SE $(        ) - 40% Standard = Countable FS SE $(        )
  CALCULATE Y/N ( )
                                                                More
 MESSAGE

 13-bott
```

Include the following:

- Calculation of countable self-employed income

DEAL

Access REMA to enter documentation

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

Client Name                              Client ID 195455980

----------- 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
```

Include the following:

- Alien sponsor's name and address

- Names of persons counted as IRS dependents for deeming

- Names of persons income can be allocated to for allocation

CARE

Access REMA to enter documentation

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

Client Name                               Client ID

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
```

Include the following:

- Childcare arrangements if AR is eligible for deduction but incurs no expense

- Subsidized childcare if provided

- List each child individually if expense is incurred

UINC

Access REMA to enter documentation

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

Client Name                                 Client ID

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

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

Include the following:

- Date payments begin and/or terminate

- Source and expected duration of contributions

- Reason net amount used instead of gross

- Calculation of monthly interest payment or child support payment

- Financial aid for students

- Reason for changes to auto update

- Reason any fluctuating income is not considered representative

- Name and relationship if RSDI is received on another's account

- Details of application for other benefits; explanation for not requiring application when potentially eligible

- Clearinghouse matches and resolution of discrepancies

MISC

Access ADT to enter documentation

```
UPDATE                        REMARKS - REMA              REMA
                                                          01
   ******************************* TMA/F07 *******************************
   10/05/2006 12:35 PM Family Medicaid Training 555-555-5555
   For F07, months of eligibility :_____ to :_____
   Document reason for LIM ineligibility:_____

    :_____




                                                             More
   MESSAGE

   13-bott
```

Include the following:

▪ How first month of TMA was established

```
UPDATE                        REMARKS - REMA              REMA
                                                          01
   ************************* MISC SOP/QMB OVERRIDE *************************
   10/05/2006 12:35 PM Family Medicaid Training 555-555-5555
   OSOP problem, explain:_____
    :_____

   Reason for QMB Override:_____
    :_____




                                                             More
   MESSAGE

   13-bott
```

Include the following:

▪ Why case is over the SOP

DONE

Access NARR to enter documentation

```
UPDATE                    NARRATIVE - NARR                  NARR
                                                             01

   10/05/2006 03:55 PM Phase II Training 555-555-5555




                                                            More
   MESSAGE
        13-bott
```

Include the following:

- Date and type of SUCCESS letter; include Load ID and name of Case Manager

- Date and type of information indicated on verification checklist

CLEARINGHOUSE

Clearinghouse is an automatic on-line computer system through which wage and benefit information on applicants and recipients is matched with files in other state and federal agencies.

INTERFACES:

DEPARTMENT OF LABOR WAGES

DEPARTMENT OF LABOR UCB

NEW HIRE INFORMATION

SOCIAL SECURITY BENDEX INQUIRY

SSI STATE DATA EXCHANGE – SDX1

SSI STATE DATA EXCHANGE – SDX2

SSI STATE DATA EXCHANGE – SDX3

Do not print the information garnered from these interfaces, simply press the Tilde key to copy and paste the information to the appropriate REMA screen.

CLEARINGHOUSE - DOL WAGES

```
                         DOL   WAGE   INQUIRY  -  WGEI                    WGEI
Next SSN                                                                    01
SSN   569  12  XXXX      Benefit Year Begin Date
Sel    Employer  Name         Emplr  Num        Qtr/Yr        Wages    Sur
       FASHION CARE INC       05965114          1  07          3,859   NOR
       FASHION CARE INC       05965114          2  07          2,794   NOR
       JOE MAY VALET          63251981          3  07          3,954   NOR
       JOE MAY VALET          63251981          2  07            651   NOR




Qtr/Yr   Qtr-Total      Qtr/Yr   Qtr-Total       Qtr/Yr   Qtr-Total      Qtr/Yr   Qtr-Total
  3/06                    4/06                     1/07    3,859  2/07    3,445

Tot  Wages     7,304   Potential Amount    91     Num of  Wks    20    Max  Amt
Message

13-Bendex  14-SDX1            16-UCBI
```

When you have an A/R who has lost their job, look for potential eligibility for UCB benefits.

Compare the surname on DOL with the A/R's surname for discrepancies. The discrepancy can be for several different reasons. An incorrect SSN could have been entered by DOL or the employer, or the A/R is using another name. This could be because of a recent marriage or divorce or because the A/R is working under another name. These discrepancies must be resolved.

The Employer Address File can be accessed by entering Y in the Select Field next to the Employer's Name.

CLEARINGHOUSE - DOL UNEMPLOYMENT

```
INQUIRY        DOL    UNEMPLOMENT INSURANCE PAYMENT HISTORY - UCBI
                                                                      01
Next SSN                                          Mailing Address (UCCA)
SSN  569  12  XXXX  Month/Yr      12/07   and   13  Months Prior
SUR  WAT  Ben Yr  Begin 09/22/07 WBA 172 MBA   3268 Weeks Dur 19  Clm VALID
              Monthly  Totals        Totals  for last 10 weeks           EUC  Eff  Date
Month/Year     Paid   # of Checks         Check  Date          Amount  Paid
    12/07                                  09/28/07                 172
    11/07                                  10/05/07                 172
    10/07     688       4                  10/13/07                 172
    09/07     688       4                  10/19/07                 172
    08/07                                  10/26/07                 172
    07/07
    06/07
    05/07
    04/07
    03/07
    02/07
    01/07
    12/06

Message

13 – BNDX      14 – SDXI      15 – WGEI
```

The WBA is the maximum UCB payment that an employee is potentially
eligible to receive. The actual UCB payment may be less due to one of the
following reasons. Budget the appropriate amount based on the reason for
the difference in the amounts.

1) Taxes withheld – count gross UCB amount
2) Child Support payments deducted – count gross UCB amount
3) Part-time employment - count net UCB amount
4) Overpayment deduction – count net UCB amount **unless** the
     overpayment is the result of fraud

Enter Y in the Mailing Address field to access the UCB Claimant Address
File. Always compare the UCB address with the address in SUCCESS
because UCB checks are mailed to the address reported to the Department
of Labor.

CLEARINGHOUSE - UCB ADDRESS

INQUIRY   DOL UCB CLAIMANT MAILING ADDRESS - UCCA   UCCA

SSN   56912XXXX

              Claimant Name   KATHERINE NORWOOD
              Street Address   879 CHARTER BLVD.
              City State/Zip Code   MACON   GA   31201

Always resolve discrepancies between the address and name entered in SUCCESS and the address and name reported to DOL.

The UCB address is where the UCB check is sent. Along with this check is a stub that must be completed by the recipient verifying their job search to DOL. If the recipient does not return this completed stub, he/she will not continue to receive UCB. So it is extremely rare for a recipient not to give their actual address to UCB.

The mailing address does not display automatically. You have to select it on the previous UCB screen. Always look at the mailing address if the A/R is receiving or recently received or applied for UCB.

If you have a discrepancy between the address reported to you and the UCB address, then you have a questionable situation.

NEW HIRE INFORMATION INQUIRY

INQUIRY   W-4 EMPLOYER REPORTING SYSTEM   W4ER
NEW HIRE INFORMATION INQUIRY

SSN: 569-12-XXXX

LAST NAME: NORWOOD   FIRST NAME: KATHERINE   MI:
ADDRESS1:   879 CHARTER BLVD
ADDRESS2:
CITY: MACON   STATE: GA
ZIP CODE: 31201

D-O-B: 12/26/70   D-O-H: 01/21/08

EMPLOYER NAME: JO-MAC ENTERPRISES
FEDERAL ID: 246000685   ADDRESS1:   32 JOHNSON HWY.
PHONE: (770)   363-9251

CITY: CONYERS   STATE: GA
ZIP CODE: 30064

Message

Always compare the address the A/R provided to the employer with the address in SUCCESS. Explore and resolve any discrepancies.

The employer address may be the actual site where the A/R works, but it may also be a central business office or corporate address.

SOCIAL SECURITY – BENDEX INQUIRY

```
INQUIRY                     BENDEX INQUIRY – BNDX                        BNDX
NEXT SSN                                                                  01
Claimant Name KATHERINE  NORWOOD          DOB 12 26 70      SEX  F
County            050                     Beneficiary's own SSN   569 12 XXXX
SSA Claim Number   569 12 XXXX A          Claimant SSN           569 12 XXXX
Agency Code        110                    Category of Assistance       A
        State Control Data                Old BIC      Payment Status CP
Mo. Benefit Payable    150.00             Date of Initial Entitlement   07 93
Gross Amount Payable 150.30               Date of Current Entitlement   07 93
Net Monthly Amount    150.00              Communication Code   MAT
Black Lung Acct. No. 00000000             Prev Gross Amt 150.30  Date    11 97
BL Entit/Term Date 00 00 BL Status        SSI Entit/Term Dt 06 93    Status   E
BL Payment Amount  0.00                   Monthly Overpymt Deducted     0.00
RR Claim No   RR Status                   End Date Overpayment       00.00
SMI Option Code        Y      Date Entitled 06 96   H.I. Option Code E  Amt      0.00
SMI Premium Amt     78.20 Date Term    00 00   H.I. Date Entit/Term   06 96
SMI Premium Payer   110
SMI 3rd Party DT Entit/Term       00 00   Disab Onset 00 00    Direct Dep  C
Dual Entit SSN          000 00 000        Trip Entit SSN       000 00 0000


Message
0020   INQUIRY COMPLETED SUCCESSFULLY
    14 – sdx     15 – wgei      16 – ucbi
```

Monthly Benefit Payable – This is the net amount of the RSDI payment.

Gross Amount Payable – This is the gross monthly RSDI payment due before any deductions for Medicare. This is the RSDI payment, including cents, which should be budgeted in SUCCESS unless an overpayment is being deducted. However, if the overpayment is due to fraud, then the gross amount is budgeted.

SMI Fields – The Option Code field indicates the Medicare eligibility status. Codes G and Y indicate eligibility; other letters indicate ineligibility for Medicare. The amount indicated in the SMI Premium Amount field indicates the amount of the Medicare premium. The SMI Premium Payer field indicates who pays the premium. The code 110 indicates the State is paying the premium; Self indicates the AR pays the premium.

SSI – SDX1 INQUIRY

```
INQUIRY              STATE DATA  EXCHANGE - SDX1                      SDX1
NEXT  SSN                                                                    01
Client  Name  KATHERINE          NORWOOD              Client   ID
     DOB  12  26  1970      Race  B        Individual SSN 569  12  XXXX
Date  of                  Mrtl   Alien  Es.  Pers.  --SDX Transaction--  Multiple
  Death      Sex  Sts   Code    Ind           Code       Date       SSN
              F     3      N       0            08      11 23 04        0
  Appl   Denial     Denial   Appeal      Appeal    Onset Disab/   SSI Elig  Medicd
  Date    Date      Code     Date        Code      Blindness       Date     Test
06 09 93                                            06 09 93      06 09 93
Chg Dt   Pay Stat  Fed Liv  State/Cnty
06 93         C01    A        11530      FS    FS     FS Input   TPL   Medicd
                                         Appl  Stat   Date       Cd    Eff Dt
                                         N     N      07 93      N     06 09 93

                                              ---- STATE  SUPPLEMENT ----
Adv  Pay  Bdgt Mo.  SSI/GPA Mthly  Asst    Amt  Pd   Elig  Pd   Grant
        2    328.00      262.00
----------------- OVERPAYMENT ----------------   -------------- RESOURCES -----------
Ind    Balance  Waiver Amt  Waiver  Date     House   MV  Lfe Ins  Prop
                                               Z      B     Z      Z

Message
```

SSI/GPA – This is the gross amount that the A/R is entitled to receive before any overpayments are withheld.

Mthly Asst – The monthly assistance is the actual amount of the SSI payment. If this payment is less than the SSI/GPA, then an overpayment is being withheld. The monthly assistance payment should always be used in the budget.

SSI – SDX2 INQUIRY

```
INQUIRY                    STATE  DATA  EXCHANGE – SDX2                    SDX2
                                                                             01
Client  Name  KATHERINE          NORWOOD                    Client  ID
         DOB 12  26  1970                        Individual SSN  569  12  XXXX

EI  Net  Amt   UI  Net  Amt   Deemed  Inc  Amt     SSI/GPA       Mthly  Asst
                   250.00                            328.00        262.00
-------------------- EARNED  INCOME  INFORMATION ---------------------------------------
Period              Wage  Est    Self-em.  Est        Blind           PASS

-------------------- UNEARNED  INCOME  INFORMATION    ------------------------------------
         Type       Recip  Amt      Start  Dt    Stop  Dt      Claim  Num       Freq  Cd
         A           270.00          01  08                    152409860  8        C
         A           264.00          01  07      12  07        152409860  8        T
         S            40.00          01  07      01  07        CASH  FR  SON      N



Message
```

Type - This indicates the type of unearned income reported to the Social Security Administration. The codes for the most common types of unearned income are:

A – Social Security (RSDI)
C, E – Both of these codes are for VA income
H – In-kind Income. This refers to the support provided by someone that the A/R lives with. This is a monetary valuation that SSS assigns to the assistance (usually the providing of housing) that the A/R receives. It is not actually income and would not be budgeted in FS. However, it usually indicates that there is another HH member.
N – Child Support
Q – Worker's Compensation
S – Other. This indicates income for which a code does not exist. It is usually explained under Claim Number. Note that in our example, this other income is documented as Cash Fr(om) Son.

SSI – SDX3 INQUIRY

```
INQUIRY                    STATE  DATA  EXCHANGE  -  SDX3                SDX3
                                                                            01
Client  Name  KATHERINE           NORWOOD                          Client  ID
        DOB  12  26  1970                            Individual  SSN  569  12  XXXX

     Payee  Name  and  Address                              Residence  Address
MARY  NORWOOD  FOR                          879 CHARTER BLVD
KATHERINE NORWOOD                           MACON                GA
2561  JONES  ROAD                           31201-6940
MACON                GA
31201-9861




Message

     PF13   BNDX          PF15   WGE1          PF16   UCBI
```

The SDX3 screen indicates the residential address of the SSI recipient and, if applicable, their payee for the check along with the mailing address.

Compare these addresses to what has been entered in SUCCESS and resolve any discrepancies.

V I T A L   R E C O R D S

Vital Records data is available for Case Managers to use as a method of verifying public information. There are four databases that can be accessed.

INQUIRIES:

BIRTH INDEX

DEATH INDEX

MARRIAGE INDEX

DIVORCE INDEX

Do not print nor copy and paste the information garnered from Vital Record screens. The information is confidential. **Document case files but do not put screen prints in the case records. Client specific data from the Birth Index only may be copied and pasted in the documentation.**

GO SCREEN

- Type DHR to access databases

```
DHR                GGGGGGGGGGGGGGGGGGGG          OOOOOOOOOOOOOOOOOOOO
                   GGGGGGGGGGGGGGGGGGGGGG        OOOOOOOOOOOOOOOOOOOO
            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
         GGGGGGGGGGGGGGGGGGGGGGGG            OOOOOOOOOOOOOOOOOOOO
         GGGGGGGGGGGGGGGGGGGGGG             OOOOOOOOOOOOOOOOOOOO

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                    as well as all applicable FEDERAL laws.
```

SIGN ON MENU

- Select 02 to access $TARS

- Enter RACF ID and password

```
                  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
```

GO SCREEN

▪ Message **DFHCE3549** appears

▪ Press the Pause/Break key to clear the screen

```
DFHCE3549
                   GGGGGGGGGGGGGGGGGGGGG          OOOOOOOOOOOOOOOOOOOO
                   GGGGGGGGGGGGGGGGGGGGGGG         OOOOOOOOOOOOOOOOOOOO
                   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
               GGGGGGGGGGGGGGGGGGGGGGG         OOOOOOOOOOOOOOOOOOOO
               GGGGGGGGGGGGGGGGGGGGG          OOOOOOOOOOOOOOOOOOOO

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```

BIRTH INDEX INQUIRY

- Enter **SIBI** to access the Birth Index

- Press ENTER

```
SIBI
```

SIBI

- Enter year and last name

- Enter month and day, if known

- Press ENTER

```
                    BIRTH INDEX INQUIRY SYSTEM

DOB YR
CLNAME
DOB MO
DOB DA          SOUNDEX OFF
        SELECTION   CHILD FNAME         MO DA RS COUNTY
```

DEATH INDEX INQUIRY

- Enter **SIDT** to access the Death Index

- Press ENTER

```
SIDT
```

SIDT

- Enter year and last name

- Enter month and day, if known

- Press ENTER

```
SIDT                    DEATH INDEX INQUIRY SYSTEM
 DTH YEAR                   ENTER 4 DIGIT YEAR
 LAST NAME
 DTH MONTH
 DTH DAY
     FIRST NAME  MO DA RACE SEX AGE DEATH-COUNTY DATE-FILED
AMEND
```

DIVORCE INDEX INQUIRY

- Enter **SIDV** to access the Divorce Index

- Press ENTER

```
SIDV




```

SIDV

- Enter year and last name

- Enter month and day, if known

- Press ENTER

```
 SIDV                    DIVORCE INDEX SEARCH
DIV YEAR          ENTER 4 DIGIT YEAR
LAST NAME
DIV MONTH
DIV DAY
     GIVEN NAME     R AGE MO DA CTY SURNAME  GIVEN NAME  R
AGE


```

MARRIAGE INDEX INQUIRY

- Enter **SIMI** to access the Marriage Index

- Press ENTER

```
SIMI



```

SIMI

- Enter year and last name

- Enter month and day, if known

- Press ENTER

```
SIMI                    MARRIAGE INDEX SEARCH
   MAR YEAR              ENTER 4 DIGIT YEAR
 LAST NAME
 MAR MONTH
 MAR DAY
      GIVEN NAME     R AGE MO DA CTY SURNAME  GIVEN NAME  R
AGE


```

GEORGIA DATA BROKER

Georgia Data Broker is a web-based application that provides a single point of access to a comprehensive database of national and state-specific public records from a variety of data sources.

DATA SOURCES:

CREDIT REPORT

DRIVER'S LICENSE

REAL PROPERTY

VEHICLE REGISTRATIONS

FAA AIRCRAFT REGISTRATIONS & PILOT LICENSES

WATERCRAFT STATE REGISTRATIONS

PROFESSIONAL LICENSES

BUSINESS INFORMATION REPORT

FEDERAL EMPLOYER ID NUMBER

FICTITIOUS BUSINESS NAME

UNIFORM COMMERCIAL CODE

BANKRUPTCIES, LIENS AND JUDGMENTS

Data Broker searches are not required on RSM PG or RSM Child cases. For all other classes of assistance, conduct a search of all household members age 18 and over. Copy and paste or document any information provided by the Data Broker search on the appropriate REMA screen.

NOTE: Information from the credit report is not to be copied and pasted. It is for informational purposes only and should be used to gain a better overall understanding of the household circumstances of the AR. The information could lead to follow up questions as to available household income and resources, and should be used as a guide in the interview process. Information in the credit report can be referenced in SUCCESS remarks, such as if the credit report shows possible new employment, but it is not to be copied in SUCCESS or the physical case record in any way.

GEORGIA DATA BROKER SYSTEM

- Enter web address

- Press ENTER

- Enter User ID and Password

- Press ENTER

PURPOSE OF USE

- Click Agree box

- Click Continue

MAIN MENU

- Select Client Inquiry

- Press ENTER

- At pop-up window, select Inquire on Individual

- Press ENTER

INQUIRY SCREEN

- Enter Last Name and First Name (Required)

- Enter SSN (Suggested)

- Enter Home Address (Suggested)

- Enter Date of Birth (Required)

- Click Search

PUBLIC RECORD REPORT

CREDIT REPORT SELECTION

- Click Agreement

- Click Continue

CREDIT REPORT

This Credit Report is an FCRA Report

Credit File Vendor: Experian
Date: 10/18/2005
File Reference: 039438576567373

Alerts

I May have asset related information in the public records section; therefore, check the public records section.

Informational Messages

CONSUMER CREDIT INFORMATION IN THIS REPORT OBTAINED FROM EXPERIAN NATIONAL CREDIT FILE FOR BUSINESS AND GOVERNMENT SERVICES.

Report Request Search Critera

Case: 20070611_04
Report Type: Applicant
Full Name: MARY A. GIBBS
Date of Birth: xx/xx/xxxx
SSN: 111223333
Address: 601 LEE BYRD RD
LOGANVILLE 30052-0000

Credit Report Information Sheet

Name: MARY A GIBBS
Date of Birth: xx/xx/xxxx
SSN: 111223333
Former Name: MARY ANN PARCELLS
Former Name: MARYANN PARCELLS

Back to Top

Aliases

Name: MARY ANN GIBBS ANN GIBBS

Back to Top

Address Information

Street Address: 601 Lee Byrd RD Loganville 30052-2618
Dates at this Address: 01/01/2004 - 08/01/2005

Back to Top

INFOPAC REPORTS

INFOPAC is a separate database accessible from the GO screen that contains various county reports related to the SUCCESS system and public assistance programs administered by DFCS.

COMMON REPORTS:

COUNTY ALPHABETICAL LISTING

LIST OF ACTIVE CASES DUE FOR REVIEW

CASE ASSIGNMENT REPORT

MONTHLY APPLICATION OSOP REPORT

SANCTIONED CLIENTS IN ACTIVE TANF/ ARM/FS CASES

These reports are designed to assist the Case Manager in managing their caseloads by providing a wealth of information that may necessitate action to ensure accuracy.

GO Screen

- Enter INFODMP

- Press ENTER

```
INFODMP
                GGGGGGGGGGGGGGGGGGGG            OOOOOOOOOOOOOOOOOOOO
                GGGGGGGGGGGGGGGGGGGGG           OOOOOOOOOOOOOOOOOOOO
          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
      GGGGGGGGGGGGGGGGGGGGGGGG          OOOOOOOOOOOOOOOOOOOO
      GGGGGGGGGGGGGGGGGGGGGG            OOOOOOOOOOOOOOOOOOOO

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                    as well as all applicable FEDERAL laws.
```

INFOPAC

- Enter County Code in Recipient ID field

- Press ENTER

```
                          ViewDirect

              *******************   *****
             *******************  ****************
           ******************   ***********************
          ******************       **********************
         ******************         **********************
        *****************            **********************
       ****************              *********************
      ***************               **********************
       ***************              ***********************
        ***************             **********************
         *******************    ***********************
          **************   **************************
            ******   **************************


      -----------------------------------------------------------
       M O B I U S   M A N A G E M E N T   S Y S T E M S,   I N C.
      -----------------------------------------------------------

                   Recipient ID:
                   Password    :
                   New Password:

                    PF01 –Help   PF03-EXIT
```

VIEWING MENU

- Press ENTER

```
COMMAND ===>                                                    TIME:  092242
                              *** ViewDirect ***
                                VIEWING MENU

RECIPIENT ID:  XXXX                                            VERSION:  6.2
                                                        TAPE VOLSER:  LC6458

                  ACCESS OPTIONS:      R   (R/T)     R=REPORT
                                                     T=TOPIC

              REPORT/TOPIC/QUEUE ID:    _____
                         VERSION:       _____ _____
                         SECTION:       _____

        DISPLAY LIST OF REPORTS/TOPICS:   YES (YES/NO)
          DISPLAY LIST OF VERSIONS:       YES (YES/NO)
             DISPLAY SECTION INDEX:       YES (YES/NO)


PF01=HELP  PF02=PRINT    PF03=END     PF04=MENU PF05=RFIND PF06=MARK
PF07=UP         PF08=DOWN     PF09=          PF10=LEFT  PF11=RIGHT PF12=QUIT
```

REPORTS

- Enter X in Option Field to indicate report to be viewed

- Press ENTER

```
COMMAND ===>                                                    TIME:  092242
                              *** REPORTS ***

OPTION     REPORT ID     REPORT NAME
--------------------------------------------------------------------------------
  X        DMF800BI      COUNTY ALPHABETICAL LISTING
  _        DMF800CI      STATEWIDE WORKER LIST BY COUNTY WITH MEDICAID
  _        DMF800HI      17+ MONTH DETAIL BY MONTHS BY LOCAL OFFICE
  _        DMF800II      17+ MONTH DETAIL BY NAME BY LOCAL OFFICE
  _        DMF800JI      SUCCESS LIFETIME LIMIT FILE – 48+ MONTHS
  _        DMF800KI      17+ MONTHS DETAIL BY MONTH
  _        DMF800LI      17+ MONTHS DETAIL BY MONTHS – SUPV LEVELL
  _        DMF800MI      17+ MONTHS DETAIL BY NAME
  _        DMF800NI      17+ MONTHS DETAIL BY NAME – SUPV LEVEL
  _        DMF800OI      MONTHS SUMMARY FOR COUNTY/STATE
  _        DMF800TI      LIST OF ACTIVE CASES DUE FOR REVIEW
  _        DMF8001I      APPLICATION ACTIVITY REPORT
  _        DMF8002I      AU Benefits Report
  _        DMF8003I      MOTOR VOTER REPORT
  _        DMF8005I      AU Size Report

PF01=HELP  PF02=PRINT    PF03=END     PF04=MENU  PF05=RFIND  PF06=MARK
```

REPORT VERSIONS

- Enter X in the Option Field to indicate report month to be viewed

- Press ENTER

```
0727I-BEGINNING OF VERSIONS
COMMAND ===>                                                    TIME:  092242
                                *** REPORT VERSIONS ***

REPORT:    DMF800BI    COUNTY ALPHABETICAL LISTING

    OPTION       DATE        TIME    DEVICE  STATUS
    ------     ---------    ------   ------  --------------------
      X         20060803    081546   DISK     AVAILABLE
      _         20060703    081518   DISK     RECALL REQUIRED
      _         20060603    081519   DISK     RECALL REQUIRED
      _         20060502    122257   DISK     RECALL REQUIRED
      _         20060402    081533   DISK     RECALL REQUIRED
      _         20060305    081513   DISK     RECALL REQUIRED
      _         20060202    081532   DISK     RECALL REQUIRED
      _         20060103    081514   DISK     RECALL REQUIRED
      _         20051203    081545   DISK     RECALL REQUIRED
      _         20051102    081532   DISK     RECALL REQUIRED
      _         20051003    081514   DISK     RECALL REQUIRED
      _         20050903    081534   DISK     RECALL REQUIRED

PF01=HELP  PF02=PRINT    PF03=END      PF04=MENU  PF05=RFIND  PF06=MARK
```

REPORT SECTION INDEX

- Enter X in the Option Field to view selected report

- Press ENTER

```
0727I-BEGINNING OF INDEX              0731I-END OF INDEX
COMMAND ===>                                                    TIME:  092242
                             *** REPORT SECTION INDEX ***

REPORT ID:  DMF800BI     COUNTY ALPHABETICAL LISTING
  VERSION:  20060803 081546

OPTION     SECTION                     PAGES   DESCRIPTION
------     ----------------------------- ------ ---------------------------------------
   X       DMF800BI049                    74
```

COUNTY ALPHABETICAL LISTING

▪ View report

```
COMMAND ===>                                              SCROLL ==> SCREEN
DMF800BI   20060803 081546 DMF800BI049              P     1 R 1 C 1
DMF800BA-DMF800BI                     GEORGIA DEPARTMENT OF HUMAN RESO
AS OF DATE: 09/30/06

                                      COUNTY ALPHABETICAL LISTING

                                        COUNTY 049 TRAINING
  AU NO        CL NO        AU NAME                       AU SSN      LO/UN
                                                             NUM  I
XXXX00190  XXXX000283   ARROYO          ALLISON       99911XXXX     059/03
XXXX00191  XXXX000283   ARROYO          ALLISON       99911XXXX     059/03
XXXX00186  XXXX000276   COLLINS         JUDY          11401XXXX     059/03
XXXX00187  XXXX000276   COLLINS         JUDY          11401XXXX     059/03
XXXX00193  XXXX000287   D'AGOSTINO      ELAINE                      059/03
XXXX00172  XXXX000243   DAILY           ANNE          62666XXXX     059/03
XXXX00008  XXXX000005   GREEN           MITCHELL      55301XXXX     059/03
XXXX00009  XXXX000005   GREEN           MITCHELL      55301XXXX     059/03
XXXX00011  XXXX000008   HORTON          HERMAN        55401XXXX     059/03
XXXX00012  XXXX000008   HORTON          HERMAN        55401XXXX     059/03
XXXX00197  XXXX000292   KLEIN           ANTONIO       77901XXXX     059/03
XXXX00192  XXXX000286   KRUCHEV         INID                        059/03
XXXX00025  XXXX000024   NELSON          KAREN         22515XXXX     059/03
XXXX00188  XXXX000279   NELSON          SUSAN         31901XXXX     059/03
XXXX00189  XXXX000279   NELSON          SUSAN         31901XXXX     059/03
XXXX00198  XXXX000296   NORTON          CHRISTINA     66601XXXX     059/03
XXXX00199  XXXX000296   NORTON          CHRISTINA     66601XXXX     059/03
```

REPORTS

- Enter X in the Option field to indicate report to be viewed

- Press ENTER

```
COMMAND ===>                                                TIME:  092242
                             *** REPORTS ***

OPTION      REPORT ID     REPORT NAME
--------------------------------------------------------------------------------
   _        DMF800BI      COUNTY ALPHABETICAL LISTING
   _        DMF800CI      STATEWIDE WORKER LIST BY COUNTY WITH MEDICAID
   _        DMF800HI      17+ MONTH DETAIL BY MONTHS BY LOCAL OFFICE
   _        DMF800II      17+ MONTH DETAIL BY NAME BY LOCAL OFFICE
   _        DMF800JI      SUCCESS LIFETIME LIMIT FILE – 48+ MONTHS
   _        DMF800KI      17+ MONTHS DETAIL BY MONTH
   _        DMF800LI      17+ MONTHS DETAIL BY MONTHS – SUPV LEVELL
   _        DMF800MI      17+ MONTHS DETAIL BY NAME
   _        DMF800NI      17+ MONTHS DETAIL BY NAME – SUPV LEVEL
   _        DMF800OI      MONTHS SUMMARY FOR COUNTY/STATE
   X        DMF800TI      LIST OF ACTIVE CASES DUE FOR REVIEW
   _        DMF8001I      APPLICATION ACTIVITY REPORT
   _        DMF8002I      AU Benefits Report
   _        DMF8003I      MOTOR VOTER REPORT
   _        DMF8005I      AU Size Report


PF01=HELP  PF02=PRINT    PF03=END      PF04=MENU  PF05=RFIND  PF06=MARK
```

REPORT VERSIONS

- Enter X in the Option Field to indicate report month to be viewed

- Press ENTER

```
0727I-BEGINNING OF VERSIONS
COMMAND ===>                                                TIME:  092242
                          *** REPORT VERSIONS ***

REPORT:   DMF800BI     COUNTY ALPHABETICAL LISTING

   OPTION        DATE        TIME    DEVICE STATUS
   ------     ---------     ------   ------ --------------------
     X         20060803     081546   DISK   AVAILABLE
     _         20060703     081518   DISK   AVAILABLE
     _         20060603     081519   DISK   AVAILABLE
     _         20060502     122257   DISK   AVAILABLE
     _         20060402     081533   DISK   AVAILABLE
     _         20060305     081513   DISK   AVAILABLE
     _         20060202     081532   DISK   AVAILABLE
     _         20060103     081514   DISK   AVAILABLE
     _         20051203     081545   DISK   AVAILABLE
     _         20051102     081532   DISK   RECALL REQUIRED
     _         20051003     081514   DISK   RECALL REQUIRED
     _         20050903     081534   DISK   RECALL REQUIRED

PF01=HELP  PF02=PRINT    PF03=END      PF04=MENU  PF05=RFIND  PF06=MARK
```

REPORT SECTION INDEX

- Enter X in the Option Field to view selected report

- Press ENTER

```
0727I-BEGINNING OF INDEX              0731I-END OF INDEX
COMMAND ===>                                              TIME:  092242
                          *** REPORT SECTION INDEX ***

REPORT ID:  DMF800TI    LIST OF ACTIVE CASES DUE FOR REVIEW
  VERSION:  20060803 081546

OPTION     SECTION                       PAGES   DESCRIPTION
------     ----------------------------- ------- ---------------------------------------
  X        DMF800TI049059035XXXXE             1
  _        DMF800TI049059035XXXXE             3
  _        DMF800TI049059035XXXXE             3
  _        DMF800TI049059035XXXXE             3
  _        DMF800TI049059035XXXXE             1
  _        DMF800TI049059035XXXXE             1
```

ACTIVE CASES DUE FOR REVIEW

- View report

```
COMMAND ===>                                       SCROLL ==> SCREEN
DMF800BI   20060803 081546 DMF800TI049059035XXXXE          P      1 R 1 C 1
DMF800TA-DMF800TI                        DEPARTMENT OF HUMAN RESOURCES
RUN DATE: 10/02/06                       DIVISION OF FAMILY AND CHILDREN SE
                                            ACTIVE CASES DUE FOR REVIEW F

               COUNTY 049 – TRAINING              OFFICE 059   SUPERV

        AU NUMBER     LAST NAME          FIRST NAME   MI  PGM TYPE

        XXXX00074     BROOKS             ELAINE           FS
        XXXX00015     CAMP               GLORIA           MA
        XXXX00018     CAMP               GLORIA           FS
        XXXX00042     COMER              JANICE           MA
        XXXX00016     DANIEL             ALEXIS           MA
        XXXX00045     DENTON             ANDREA           FS
        XXXX00009     GREEN              MITCHELL         FS
        XXXX00024     HART               SHARON           MA
        XXXX00012     HORTON             HERMAN           FS
        XXXX00081     HUGHES             TERESA           FS
        XXXX00087     MITFORD            NANCY            FS
        XXXX00057     WALKER             HARRIETT         FS
```

REPORTS

- Enter X in the Option field to indicate report to be viewed

- Press ENTER

```
COMMAND ===>                                                  TIME:  092242
                              *** REPORTS ***


OPTION     REPORT ID     REPORT NAME
--------------------------------------------------------------------------------
   _       DMF8031I      AU Load Activity Report
   _       DMF8032I      Case Maintenance Report
   _       DMF8035I      Living Arrangement Report
   X       DMF8051I      Case Assignment Report
   _       DMF8061I      Monthly Application OSOP Report
   _       DMF8062I      Weekly Application SOP Report
   _       DMF8063I      County Transfers Received Report
   _       DMF8067I      Racial/Ethnic Participation Report
   _       DMF8068I      Minor Mother Report
   _       DMF8073I      QUARTERLY HEALTH CHECK
   _       DMF8076I      30 MONTH CASH ASSISTANCE
   _       DMF8083I      ACTIVE,SUSPENDED AND PENDING EMA CASES
   _       DMF8095I      CIVIL RIGHTS COMPLIANCE
   _       DMF82ZZI      FS ABAWD NON-COMPLIANCE CASES-POTENTIALLY REQUIRE CORRECTION
   _       DMF8211I      MA EARNED INCOME DISREGARD CONVERSION TO RM

PF01=HELP  PF02=PRINT    PF03=END     PF04=MENU  PF05=RFIND PF06=MARK
PF07=UP         PF08=DOWN      PF09=          PF10=LEFT  PF11=RIGHT PF12=QUIT
```

REPORT VERSIONS

- Enter X in the Option Field to indicate report month to be viewed

- Press ENTER

```
0727I-BEGINNING OF VERSIONS
COMMAND ===>                                                  TIME:  092242
                           *** REPORT VERSIONS ***


REPORT:    DMF8051I     Case Assignment Report

   OPTION          DATE          TIME   DEVICE STATUS
   ------       ---------      ------ ------ ---------------------
     X           20061005      081546 DISK    AVAILABLE
     _           20060905      081518 DISK    AVAILABLE
     _           20060805      081519 DISK    AVAILABLE
     _           20060705      122257 DISK    AVAILABLE
     _           20060605      081533 DISK    AVAILABLE
     _           20060505      081513 DISK    AVAILABLE
     _           20060405      081532 DISK    AVAILABLE
     _           20060306      081514 DISK    AVAILABLE
     _           20060205      081545 DISK    RECALL REQUIRED
     _           20060105      081532 DISK    RECALL REQUIRED
     _           20051205      081514 DISK    RECALL REQUIRED
     _           20051105      081534 DISK    RECALL REQUIRED

PF01=HELP  PF02=PRINT    PF03=END     PF04=MENU  PF05=RFIND PF06=MARK
PF07=UP         PF08=DOWN      PF09=          PF10=LEFT  PF11=RIGHT PF12=QUIT
```

REPORT SECTION INDEX

- Enter X in the Option Field to view selected report

- Press ENTER

```
COMMAND ===>                                               TIME:  092242
                        *** REPORT SECTION INDEX ***

REPORT ID:  DMF8051I    Case Assignment Report
  VERSION:  20061005 081546

OPTION     SECTION                        PAGES  DESCRIPTION
------     ----------------------------   -----  --------------------------------------
   X       DMF8051I 49 59XXXX                 2
   _       DMF8051I 49 59XXXX                 3
   _       DMF8051I 49 59XXXX                 2
   _       DMF8051I 49 59XXXX                 2
```

CASE ASSIGNMENT REPORT

- View report

```
COMMAND ===>                                          SCROLL ==> SCREEN
DMF8051I    20061005 081546 DMF8051I 49 59XXXX             P     1 R 1 C 1
DMF8096A-DMF8051I                     GEORGIA DEPARTMENT OF HUMAN RESOUR
RUN DATE: 10/05/06                    DIVISION OF FAMILY AND CHILDREN SER
                                      CASE ASSIGNMENT REPORT FOR OCTOBER
              COUNTY    :   49  TRAINING                             OFFIC
              UNIT   :  XXXX TRAINER


---------------------ASSISTANCE UNIT ------------------AU      AU       PGM
LAST NAME        FIRST NAME   MI       SSN      STS    NUMBER   CDE
BRYANT           TONYA                 00110XXXX  A    XXXX00028  MA
BRYANT           TONYA                 00110XXXX  A    XXXX00027  MA
BRYANT           TONYA                 00110XXXX  A    XXXX00026  FS
CAMP             GLORIA               55101XXXX  A    XXXX00015  MA
CAMP             GLORIA               55101XXXX  A    XXXX00018  FS
DENTON           ANDREA               01291XXXX  A    XXXX00046  MA
DENTON           ANDREA               01291XXXX  A    XXXX00045  FS
EVANS            SUSAN                75101XXXX  D    XXXX00132  MA
EVANS            SUSAN                75101XXXX  D    XXXX00131  FS
GREEN            MITCHELL             55301XXXX  A    XXXX00008  MA
GREEN            MITCHELL             55301XXXX  A    XXXX00009  FS
HALL             SALLY                25796XXXX  P    XXXX00175  MA
HALL             SALLY                25796XXXX  P    XXXX00174  FS
HORTON           HERMAN               55401XXXX  A    XXXX00011  MA
HORTON           HERMAN               55401XXXX  A    XXXX00012  FS
RAMSEY           SALLY                00114XXXX  A    XXXX00031  MA
RAMSEY           SALLY                00114XXXX  A    XXXX00034  FS
SIMON            MARGARET      K      32215XXXX  A    XXXX00102  MA
SIMON            MARGARET      K      32215XXXX  A    XXXX00101  FS
WILSON           DAVID                00130XXXX  D    XXXX00035  MA
WILSON           DAVID                00130XXXX  A    XXXX00034  FS
```

REPORTS

- Enter X in the Option field to indicate report to be viewed

- Press ENTER

```
COMMAND ===>                                                  TIME:  092242
                              *** REPORTS ***


OPTION      REPORT ID     REPORT NAME
--------------------------------------------------------------------------------
   _        DMF8031I      AU Load Activity Report
   _        DMF8032I      Case Maintenance Report
   _        DMF8035I      Living Arrangement Report
   _        DMF8051I      Case Assignment Report
   X        DMF8061I      Monthly Application OSOP Report
   _        DMF8062I      Weekly Application SOP Report
   _        DMF8063I      County Transfers Received Report
   _        DMF8067I      Racial/Ethnic Participation Report
   _        DMF8068I      Minor Mother Report
   _        DMF8073I      QUARTERLY HEALTH CHECK
   _        DMF8076I      30 MONTH CASH ASSISTANCE
   _        DMF8083I      ACTIVE,SUSPENDED AND PENDING EMA CASES
   _        DMF8095I      CIVIL RIGHTS COMPLIANCE
   _        DMF82ZZI      FS ABAWD NON-COMPLIANCE CASES-POTENTIALLY REQUIRE CORRECTION
   _        DMF8211I      MA EARNED INCOME DISREGARD CONVERSION TO RM

PF01=HELP  PF02=PRINT    PF03=END      PF04=MENU  PF05=RFIND  PF06=MARK
PF07=UP         PF08=DOWN      PF09=       PF10=LEFT  PF11=RIGHT  PF12=QUIT
```

REPORT VERSIONS

- Enter X in the Option Field to indicate report month to be viewed

- Press ENTER

```
0727I-BEGINNING OF VERSIONS
COMMAND ===>                                                  TIME:  092242
                           *** REPORT VERSIONS ***

REPORT:    DMF8061I     Monthly Application OSOP Report

   OPTION         DATE         TIME   DEVICE  STATUS
   ------      ---------      ------  ------  ----------------------
     X         20060803      081546  DISK    AVAILABLE
     _         20060703      081518  DISK    AVAILABLE
     _         20060603      081519  DISK    AVAILABLE
     _         20060502      122257  DISK    AVAILABLE
     _         20060402      081533  DISK    AVAILABLE
     _         20060305      081513  DISK    AVAILABLE
     _         20060202      081532  DISK    AVAILABLE
     _         20060103      081514  DISK    AVAILABLE
     _         20051203      081545  DISK    RECALL REQUIRED
     _         20051102      081532  DISK    RECALL REQUIRED
     _         20051003      081514  DISK    RECALL REQUIRED
     _         20050903      081534  DISK    RECALL REQUIRED

PF01=HELP  PF02=PRINT    PF03=END      PF04=MENU  PF05=RFIND  PF06=MARK
PF07=UP         PF08=DOWN      PF09=       PF10=LEFT  PF11=RIGHT  PF12=QUIT
```

REPORT SECTION INDEX

- Enter X in the Option Field to view selected report

- Press ENTER

```
COMMAND ===>                                              TIME:  092242
                          *** REPORT SECTION INDEX ***

REPORT ID:  DMF8061I     Monthly Application OSOP Report
  VERSION:   20060803 081546

OPTION      SECTION                      PAGES   DESCRIPTION
------      ---------------------------- ------  ----------------------------------------
   X        DMF8061I 49 59XXXX                2
```

MONTHLY APPLICATION OSOP REPORT

- View report

```
COMMAND ===>                                            SCROLL ==> SCREEN
DMF8061I    20060803 081546 DMF8061I 49 59XXXX          P      1 R 1 C  1
DMF8008A-DMF8061I                          GEORGIA DEPARTMENT OF HUMAN RESOUR
RUN DATE: 10/02/06                         DIVISION OF FAMILY AND CHILDREN SER
                                           APPLICATION SOP REPORT FOR OCTOBER
                     COUNTY   :  49  TRAINING                          OFFIC
                     UNIT  :  XXXX TRAINER
LOAD   PGM   PGM       -----------------HEAD OF AU----------------------
 ID    CDE   TYP  COA    LAST NAME           FIRST NAME    MI     SSN         N

XXXX   FS    S         GRIFFITH            ARTHUR               21335XXXX    02
               COA TOTAL    :    1
             PROGRAM TYPE TOTAL:   1

XXXX   MA    F         KING                ANTHONY              51299XXXX    10
               COA TOTAL    :    1
             PROGRAM TYPE TOTAL:   1
```

REPORTS

- Enter X in the Option field to indicate report to be viewed

- Press ENTER

```
COMMAND ===>                                              TIME:  092242
                              *** REPORTS ***


OPTION      REPORT ID     REPORT NAME
------------------------------------------------------------------------------
    _       DMF8246I      MA CASES CLOSED BY MASS MOD
    _       DMF8250I      FS RACIAL/ETHNIC PARTICIPATION REPORT – COUNTY
    _       DMF8252I      TANF RACIAL/ETHNIC PARTICIPATION REPORT – COUNTY
    _       DMF8254I      MA RACIAL/ETHNIC PARTICIPATION REPORT – COUNTY
    _       DMF8271I      INDIVUALS IN ACTIVE/PENDING FS AU CODED AS AB AE RA
    _       DMF8272I      CLIENT UNDER AGE 18 IN FS ABAWD CASES
    _       DMF8273I      INDIVDIUALS IN AN ACTIVE.PENDING FS AU CODED NM
    X       DMF8278I      SANCTIONED CLIENTS IN ACTIVE/TANF/ARM/FS CASES
    _       DMF8279I      ACTIVE CASES WITH ALIENS REPORT
    _       DMF8280I      ACTIVE FS CASE: ALLOTMENT AMOUNT OVER 250
    _       DMF8282I      CHILDREN IN CASES BORN BETWEEN 09/01/95 – 08/31/97
    _       DMF8283I      ELIGIBLE MEDICAID RECIPIENTS UNDER AGE 21
    _       DMF8284I      LIST OF CLOSED TANF CASES WITH REASON CODE 566
    _       DMF8285I      UNEMPLOYED ADULT MEMBERS OF ACTIVE FS CASES
    _       DMF8287I      CLOSURE 571 FOR MEMBERS IN ACTIVE FS CASES


PF01=HELP  PF02=PRINT    PF03=END     PF04=MENU  PF05=RFIND  PF06=MARK
PF07=UP         PF08=DOWN      PF09=          PF10=LEFT  PF11=RIGHT  PF12=QUIT
```

REPORT VERSIONS

- Enter X in the Option Field to indicate report month to be viewed

- Press ENTER

```
COMMAND ===>                                              TIME:  092242
                           *** REPORT VERSIONS ***

REPORT:   DMF8278I     SANCTIONED CLIENTS IN ACTIVE TANF/ARM/FS CASES

   OPTION        DATE         TIME   DEVICE STATUS
   ------      ---------      ------ ------ --------------------
     X         20060803      081546 DISK   AVAILABLE
     _         20060703      081518 DISK   RECALL REQUIRED
     _         20060603      081519 DISK   RECALL REQUIRED
     _         20060502      122257 DISK   RECALL REQUIRED







PF01=HELP  PF02=PRINT    PF03=END     PF04=MENU  PF05=RFIND  PF06=MARK
PF07=UP         PF08=DOWN      PF09=          PF10=LEFT  PF11=RIGHT  PF12=QUIT
```

REPORT SECTION INDEX

- Enter X in the Option Field to view selected report

- Press ENTER

```
COMMAND ===>                                            TIME:  092242
                        *** REPORT SECTION INDEX ***

REPORT ID:  DMF8278I    SANCTIONED CLIENTS IN ACTIVE TANF/ARM/FS CASES
  VERSION:  20060803 081546

OPTION     SECTION                     PAGES   DESCRIPTION
------     --------------------------- ------- ----------------------------------------
  X        DMF8278I049059035XXXXE           1
  _        DMF8278I049059035XXXXE           1
  _        DMF8278I049059035XXXXE           1
  _        DMF8278I049059035XXXXE           1
```

SANCTIONED CLIENTS IN ACTIVE TANF/ARM/FS CASES

- View report

```
COMMAND ===>                                        SCROLL ==> SCREEN
DMF8278I    20060803 081546 DMF8278I049059035XXXXE       P    1 R 1 C 1
DMF8278A-DMF8278I                           GEORGIA DEPARTMENT OF HUMAN RES
RUN DATE: 10/02/06                          DIVISION OF FAMILY AND CHILDREN
                        SANCTIONED CLIENTS IN ACTIVE TANF/ARM/FS CASES      S
        COUNTY 049            LOCAL OFFICE   059              SUPERVISOR
AU NAME                 AU NUMBER  PGRM  COA  SA MEMBER                    CLI
----------------------- ---------  ----  ---  ---------------------------  ---

BRYANT, TONYA           XXXX00028  FS         BRYANT, TIFFANY              250
KNOLLS, ANDREW          XXXX00185  MA    F01  KNOLLS, HEATHER              251
NORTON, CHRISTINA       XXXX00199  MA    F01  NORTON, CHRISTOPHER          251
NORWOOD, KATHERINE      XXXX00184  MA    F01  NORWOOD, TAKEYA              251
RAMSEY, SALLY           XXXX00031  FS         RAMSEY, BRAD                 250
SURMONS, PATTY          XXXX00090  MA    F01  SURMONS, DENISE              253
WILSON, DAVID           XXXX00035  FS         WILSON, JACKIE               250
                                                             LOAD ID  T
```