OSAH FORM 1

This form is available online at http://www.osah.ga.gov/ or by telephone request at (404) 657-2800.

OSAH USE ONLY DOCKET NUMBER:	AGENCY **DFCS**	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE

GEORGIA DEPARTMENT OF HUMAN SERVICES
(DFCS – Medicaid Only)

Applicant/Recipient County of Residence:	Date Request for Hearing Filed with Agency:	Agency Case Number:

Check Here if an Application Was Denied: ☐

Check Only One in This Box:

☐Case Closure ☐Reduction of Benefits ☐Disputed Determination of Benefits
☐Failure to Act Within Reasonable Time for Benefit Change
☐Agency Inaction ☐Denial of Expedited Services ☐Other:

Check Only One:

FAMILY MEDICAID REFERRALS

☐4MOCS (Child Support 3 of 6 months: § 3280)	☐LIMFE1 (Financial Eligibility/Resources: CH 2300	☐LIM (Low Income Medicaid: § 2162)
☐AAM1 (IV- Adoption: § 2817)	☐LIMFE2 (Financial Eligibility/Income: CH 2400	☐TMA (Trans Medical Assistance: § 2166)
☐CWFC (Welfare Foster: § 2890)	☐LIMOM (Ongoing Mgt: CH 2700)	☐LNH (LIM Nursing Home: § 2172)
☐EMA (Emergency Medical: § 2054)	☐NEWBORN (Newborn Medicaid: § 2174)	☐FMRETRO (FM Retroactive Medicaid: § 2053)
☐FOST (IV-E Foster Care: § 2815)	☐PEM (Presumptive Eligibility: § 2067)	☐FMA (Application: § 2050 & § 2065)
☐LIMB (Budgeting: CH 2650)	☐PWCMN (Pregnancy: § 2180 & § 2184)	☐FMAU (FM Assistance Unit: CH 2600)
☐LIMBE (Basic Eligibility: CH 2200)	☐RSM (Right from the Start: § 2180 & § 2182)	☐OTHER, specify:
☐FMN (Family Med Needy: § 2196)	☐SAAM (State Adoption Assistance: § 2895)	

AGED, BLIND OR DISABLED (ABD) REFERRALS

☐ABDB (ABD Eligibility Budget: CH 2500)	☐FSSIDC (Former SSI Disabled Child: § 2116)	☐ICWP (Independent Care Waiver § 2139)
☐ABDBE (ABD Basic Eligibility: CH 2200)	☐Hospice (Hospice Medicaid: § 2135)	☐QDWI (Qualified Disabled Working Ind:§ 2147)
☐ABDCM (ABD Case Mgt.: CH 2700)	☐Hospital (Hospital Medicaid: § 2137)	☐QI1 (Qualifying Individuals 1: § 2145)
☐ABDFR (ABD Fin Responsibility: CH 2500)	☐KATIE (Deeming Waiver: § 2133)	☐QI2 (Qualifying Individuals 2: § 2146)
☐ABDI (ABD Income: CH 2400)	☐Laurens (Head Injury Waiver: § 2933)	☐QMB (Qualified Medicare Beneficiaries: § 2143)
☐ABDL (ABD Liability/Cost: CH 2550 & 2575)	☐MRWP (Mental Retardation Waiver: § 2132)	☐SLMB (Special Low Income Medicaid Ben: § 2144)
☐ABDR (ABD Resources: CH 2300)	☐NH (Nursing Home: § 2141)	☐SSI (SSI MEDICAID: § 2111)
☐ABDRET (ABD Retroactive Medicaid: § 2053)	☐PICKLE (PL 94-566: § 2113)	☐WIDO1 (Widows & Widowers: § 2117)
☐ABDA (ABD Application § 2050 & § 2060)	☐PROTEC (PROTEC: § 2123)	☐WIDO2 (Widows & Widowers: § 2119)
☐AMN (Adult Medically Needy: § 2150)	☐MODEL (Model Waiver Program: § 2140)	☐WIDO3 (Widows & Widowers: § 2121)
☐AMNNH (AMN Nursing Home: § 2151)	☐CCSP (Community Care Services: § 2131)	☐OTHER, specify:
☐DAC (Disabled Adult Child: § 2115)	☐BCCP (Breast & Cervical Cancer: § 2198)	

APPLICANT/RECIPIENT

NAME	**TEL NO**	**FAX NO**
CURRENT ADDRESS INCLUDING ZIP CODE		**EMAIL**
ATTORNEY NAME (IF APPLICABLE)	**TEL NO**	**FAX NO**
ADDRESS INCLUDING ZIP CODE	**GEORGIA BAR NO**	**EMAIL**
PERSONAL REPRESENTATIVE NAME (IF APPLICABLE)	**TEL NO**	**FAX NO**
CURRENT ADDRESS INCLUDING ZIP CODE	**RELATIONSHIP TO CLAIMANT**	**EMAIL**

LOCAL DFCS OFFICE

NAME OF OFFICE	**TEL NO**	**FAX NO**
CURRENT ADDRESS INCLUDING ZIP CODE	**CASEWORKER FULL NAME** **CASEWORKER DIRECT TEL#:** **EMAIL**	**SUPERVISOR'S FULL NAME** **SUPERVISOR'S DIRECT TEL #:** **EMAIL**
REGIONAL HEARING COORDINATOR (*NAME AND ADDRESS*)	**REGIONAL COORDINATOR TEL#:**	**FAX #:** **EMAIL:**