OSAH FORM 1

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| **OSAH USE ONLY:** | AGENCYDFCS-M | CASE TYPE | DOCKET NUMBER | COUNTY | JUDGE |

**DHS, DIVISION OF FAMILY & CHILDREN SERVICES**

**MEDICAID**

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| **Applicant/Recipient’s County of Residence:** | **Date Hearing Request Filed with Agency:** | **Agency Case Number:**  |

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| **Check here if an application was DENIED: [ ]** **Check here if benefits were REDUCED/TERMINATED: [ ]**  | **Check here if the LEVEL OF ASSISTANCE is disputed: [ ]** **Check here if A/R requires notice of hearing in SPANISH: [ ]**  |

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| **Check Only One:** |
| AGED, BLIND, OR DISABLED (ABD) REFERRALS |
| [ ] ABDMN (ABD Medically Needy: § 2150)[ ] CCSP (Community Care Services Program: § 2131)[ ] DAC (Disabled Adult Child: § 2115) [ ] FSSIDC (Former SSI Disabled Child: § 2116)[ ] HOSPICE (Hospice Medicaid: § 2135)[ ] HOSPITAL (Hospital Medicaid: § 2137)[ ] ICWP (Independent Care Waiver Program: § 2139)[ ] KATIE (TEFRA/Katie Beckett: § 2133) | [ ] LIS (Low Income Subsidy (Extra Help for Medicare Part D): § 2146)[ ] NH (Nursing Home: § 2141)[ ] NOW/COMP (New Options Waiver/Comprehensive Supports Waiver Program: § 2132)[ ] PICKLE (PL 94-566; Pickle: § 2113)[ ] PROTEC (Protected Medicaid 1972: § 2123)[ ] QDWI (Qualified Disabled Working  Individuals: § 2147) | [ ] QI1 (Qualifying Individuals-1: § 2145)[ ] QMB (Qualified Medicare Beneficiaries: § 2143)[ ] SLMB (Specified Low-Income Medicare  Beneficiaries: § 2144)[ ] SSI (SSI Medicaid: § 2111)[ ] WID01 (Disabled Widow(er): § 2117)[ ] WID02 (Disabled Widow(er) 60-64: § 2119)[ ] WID03 (Widow(er) 1984: § 2121) |
| **FAMILY MEDICAID REFERRALS** |
| [ ] 4MEX (Four Months Extended Medicaid: § 2170)[ ] CU19 (Children Under 19 Years of Age: § 2182)[ ] FMN (Family Medicaid Medically Needy: § 2196) | [ ] NEWBORN (Newborn Medicaid: § 2174)[ ] PCWC (Parent/Caretaker with Children: § 2162)[ ] PREG (Pregnant Women: § 2184) | [ ] P4HB (Planning for Healthy Babies: § 2186)[ ] TMA (Transitional Medical Assistance: § 2166)[ ] WHM (Women’s Health Medicaid: § 2198) |
| CHILDREN IN PLACEMENT REFERRALS |
| [ ] AAM (IV-E Foster Care Medicaid: § 2817)[ ] CHAFEE (Chafee Independence Program Medicaid: § 2818)[ ] CWFC (Child Welfare Foster Care Medicaid: § 2890)  | [ ] FFC (Former Foster Care Medicaid: § 2819)[ ] FOST (IV-E Foster Care Medicaid: § 2815)[ ] SAAM (State Adoption Assistance Medicaid: § 2895) |
| **OTHER REFERRALS** |
| [ ] EMA (Emergency Medicaid Assistance: § 2054)[ ] PEM (Presumptive Eligibility Medicaid: § 2067) | [ ] RETRO (Retroactive Medicaid: § 2053)[ ] OTHER, specify:       |

# APPLICANT/RECIPIENT

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| **NAME** | TEL #:      | FAX #:      |
| CURRENT ADDRESS INCLUDING ZIP CODE:       | EMAIL:      |
| **ATTORNEY’S NAME (IF APPLICABLE)** | TEL #:      | FAX #:      |
| ADDRESS INCLUDING ZIP CODE      | GEORGIA BAR #:      | EMAIL:      |
| **PERSONAL REPRESENTATIVE’S NAME (IF APPLICABLE)** | TEL #:      | FAX #:      |
| CURRENT ADDRESS INCLUDING ZIP CODE | RELATIONSHIP TO A/R:      | EMAIL:      |

# LOCAL DFCS OFFICE

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| **NAME OF OFFICE:** | TEL #:      | FAX #:      |
| ADDRESS INCLUDING ZIP CODE: | CASEWORKER’S NAME:     CASEWORKER’S DIRECT TEL #:      EMAIL:      | SUPERVISOR’S NAME:     SUPERVISOR’S DIRECT TEL #:     EMAIL:      |
| **REGIONAL HEARING COORDINATOR (**NAME AND ADDRESS): | COORDINATOR’S DIRECT TEL #:       | FAX #:      EMAIL:      |

\*\*\* COPIES OF ADVERSE ACTION LETTER AND HEARING REQUEST MUST BE ATTACHED\*\*\*