

# OSAH FORM 1

<b>OSAH USE ONLY:</b>	AGENCY <b>DFCS-M</b>	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE
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## DHS, DIVISION OF FAMILY & CHILDREN SERVICES

### MEDICAID

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 <b>DENIED</b> : <input type="checkbox"/>	Check here if the <b>LEVEL OF ASSISTANCE</b> is disputed: <input type="checkbox"/>
Check here if benefits were <b>REDUCED/TERMINATED</b> : <input type="checkbox"/>	Check here if A/R requires notice of hearing in <b>SPANISH</b> : <input type="checkbox"/>

#### Check Only One:

#### AGED, BLIND, OR DISABLED (ABD) REFERRALS

<input type="checkbox"/> ABDMN (ABD Medically Needy: § 2150) <input type="checkbox"/> CCSP (Community Care Services Program: § 2131) <input type="checkbox"/> DAC (Disabled Adult Child: § 2115) <input type="checkbox"/> FSSIDC (Former SSI Disabled Child: § 2116) <input type="checkbox"/> HOSPICE (Hospice Medicaid: § 2135) <input type="checkbox"/> HOSPITAL (Hospital Medicaid: § 2137) <input type="checkbox"/> ICWP (Independent Care Waiver Program: § 2139) <input type="checkbox"/> KATIE (TEFRA/Katie Beckett: § 2133)	<input type="checkbox"/> LIS (Low Income Subsidy (Extra Help for Medicare Part D): § 2146) <input type="checkbox"/> NH (Nursing Home: § 2141) <input type="checkbox"/> NOW/COMP (New Options Waiver/Comprehensive Supports Waiver Program: § 2132) <input type="checkbox"/> PICKLE (PL 94-566; Pickle: § 2113) <input type="checkbox"/> PROTEC (Protected Medicaid 1972: § 2123) <input type="checkbox"/> QDWI (Qualified Disabled Working Individuals: § 2147)	<input type="checkbox"/> QI1 (Qualifying Individuals-1: § 2145) <input type="checkbox"/> QMB (Qualified Medicare Beneficiaries: § 2143) <input type="checkbox"/> SLMB (Specified Low-Income Medicare Beneficiaries: § 2144) <input type="checkbox"/> SSI (SSI Medicaid: § 2111) <input type="checkbox"/> WID01 (Disabled Widow(er): § 2117) <input type="checkbox"/> WID02 (Disabled Widow(er) 60-64: § 2119) <input type="checkbox"/> WID03 (Widow(er) 1984: § 2121)
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#### FAMILY MEDICAID REFERRALS

<input type="checkbox"/> 4MEX (Four Months Extended Medicaid: § 2170) <input type="checkbox"/> CU19 (Children Under 19 Years of Age: § 2182) <input type="checkbox"/> FMN (Family Medicaid Medically Needy: § 2196)	<input type="checkbox"/> NEWBORN (Newborn Medicaid: § 2174) <input type="checkbox"/> PCWC (Parent/Caretaker with Children: § 2162) <input type="checkbox"/> PREG (Pregnant Women: § 2184)	<input type="checkbox"/> P4HB (Planning for Healthy Babies: § 2186) <input type="checkbox"/> TMA (Transitional Medical Assistance: § 2166) <input type="checkbox"/> WHM (Women's Health Medicaid: § 2198)
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#### CHILDREN IN PLACEMENT REFERRALS

<input type="checkbox"/> AAM (IV-E Foster Care Medicaid: § 2817) <input type="checkbox"/> CHAFEE (Chafee Independence Program Medicaid: § 2818) <input type="checkbox"/> CWFC (Child Welfare Foster Care Medicaid: § 2890)	<input type="checkbox"/> FFC (Former Foster Care Medicaid: § 2819) <input type="checkbox"/> FOST (IV-E Foster Care Medicaid: § 2815) <input type="checkbox"/> SAAM (State Adoption Assistance Medicaid: § 2895)
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#### OTHER REFERRALS

<input type="checkbox"/> EMA (Emergency Medicaid Assistance: § 2054) <input type="checkbox"/> PEM (Presumptive Eligibility Medicaid: § 2067)	<input type="checkbox"/> RETRO (Retroactive Medicaid: § 2053) <input type="checkbox"/> OTHER, specify:
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#### APPLICANT/RECIPIENT

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

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

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