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)  PATH (Georgia Pathways: §§ 2195, 2256) |
| 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\*\*\*