

This package includes that printed material that you will need for the Financial Eligibility Course. It is 43 pages, and includes the following:

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Burial Space Items list from Policy Manual p. 2311-1 and 2	3
ABD Medicaid Burial Exclusion & Designation Form  (you'll need to make additional copies of this blank form for practice situations)	4-7
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**Printed material for Financial Eligibility Course Current as of January 2019**

RESOURCE TYPE	HOW IS THIS RESOURCE USUALLY VERIFIED?	POLICY MANUAL SECTION	NOTES
Vehicles	Take client statement for ownership and use; if the vehicle can't be excluded verify the value with a tag receipt or through GRATIS or NADA		One vehicle used for transportation can be totally excluded regardless of value
Checking account			
Savings account			
CD			
Nursing Home Patient Fund Account			
Pre-payment or deposit to NH			
Home place			

Burial space items may be part of a burial contract or owned outright. The following are burial space items:

- burial plot
- grave site
- crypt
- mausoleum
- casket
- urn
- niche
- other repository customarily and traditionally used for the deceased's bodily remains.

The term burial space item also includes necessary and reasonable improvement for additions to such spaces, including but not limited to the following:

- vaults
- headstones, markers or plaques
- other burial containers for caskets
- arrangements for the opening and closing of the gravesite
- contracts for the care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care.

Only the value of burial space items, which are paid in full, may be exempt from resources and the burial exclusion policy.









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June Russell, Agent  
 Carmichael Funeral Home  
 7848 Maplecreek Court  
 Augusta, GA 32015

**Invoice**  
 Invoice Number:  
 1050  
 Invoice Date:  
 Jan 9, 1993  
**Page: 1 of 1**

**Funeral Contract For:**

Samuel Haynes

Quantity	Description	Unit Price	Extension
1.00	Receiving of Remains	1540.00	1540.00
1.00	Cosmetics, Dressing and Casketing	225.00	225.00
4.00	Visitation, Viewing \$175.00/hour	175.00	700.00
1.00	Funeral Ceremony at Another Facility	495.00	495.00
1.00	Hearse Transportation for the deceased	275.00	275.00
1.00	Limousine Transportation for Family Members	265.00	265.00
1.00	Funeral Motorcycle Escort	205.00	205.00
1.00	Register/Memorial Book	45.00	45.00
1.00	Prayer Cards/Memorial Folders	90.00	90.00
1.00	Thank You Cards	45.00	45.00
1.00	Clergy Stipend	200.00	200.00
1.00	ORGANIST FEE	100.00	100.00
1.00	Out of State Funeral Home	1300.00	1300.00
1.00	Airfare	400.00	400.00
1.00	Burial/Cremation/Transportation Permit	3.00	3.00
1.00	Copy of Death Certification	20.00	20.00
1.00	Columbus Dispatch WEB fee	30.00	30.00
50.00	Columbus Dispatch SUNDAY	8.21	410.50
1.00	Full Couch Casket Spray	450.00	450.00
1.00	Small pillow for inside casket	50.00	50.00
1.00	Opening and Closing Fee at Cemetery	850.00	850.00
1.00	Navy Pin Striped	225.00	225.00
1.00	18 Gauge Metallic Full Couch Casket	2940.00	2940.00
1.00	Clark 12 Cauge Galvanized American Valor Vault	1850.00	1850.00
		Subtotal	12,713.50
		Sales Tax	402.30
		Total Invoice Amount	13,115.80
		Payment/Credit Applied	13,115.80
		TOTAL	0

**Paid in Full**

***CARMICHAEL***

Funeral Home

1177 West Fifth Avenue    Augusta, Georgia 32015    (706) 856-7863    Fax (678) 294-0198

# WOOD

## Solid Pine

\$7624.80

Included in this package are the following items and related charges:

Local transfer of Remains to Funeral Home	\$ 195.00
Embalming	\$ 625.00
Other Necessary Preparation	\$ 150.00
Basic Services of Funeral Director and Staff	\$1750.00
Facilities for viewing/visitation (per day)	\$ 395.00
Facilities/Equipment for Funeral Ceremony	\$ 545.00
Hearse	\$ 195.00
Service/Utility Vehicle	\$ 95.00
Gravesite Set Up and Service	\$ 295.00
Casket...FINLEY PINE	\$2365.00
Vault...TIARA...Standard 80 year warranted concrete	\$ 725.00
Sales Tax (7% on merchandise)	\$ 289.80

Georgia Department of Human Resources

\_\_\_\_\_ County Dept. of Family and Children Services

**ABD Medicaid Burial Contract Verification Form**

To: GRIFFIN FUNERAL HOME

Date: JULY 17, 20XX

Re: SARA PINKNEY

Case # : \_\_\_\_\_

The above named individual has applied for Medicaid. We have been advised that he/she owns a burial contract with your funeral home. Current regulations require that we verify all resources prior to approving any applicant for Medical Assistance. Please advise whether the above named has a burial contract with your funeral home and, if so, complete the following:

Name of Owner(s): SARA PINKNEY

Date contract was purchased: 6/26/2009

Is the contract itemized?  Yes  No If yes or no please attach copy of contract.  
If not itemized what type of instrument was used to fund the contract \_\_\_\_\_

Purchase price of contract \$7624.80

Is the contract paid in full?  Yes  No

If contract is **not paid in full** please complete:

Items Included in Contract	Cost upon Purchase	Paid for Y or N	Amount Owed

Cameron Myles  
Signature of Funeral Home Representative

\_\_\_\_\_  
Name of MES

Funeral Director  
Title

7/20/xx  
Date

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Charges are only for those items that are used. If we are required by law to use any items, we will explain the reasons in writing.

If you selected a funeral which requires embalming, such as funeral with viewing, you may have to pay for embalming. You do not have to pay for embalming you did not approve if you selected arrangements such as a direct cremation or immediate burial. If we charged for embalming, we will explain why.

**FUNERAL PURCHASE AGREEMENT**

*NORRIS FUNERAL HOME, INC.*

*Memorial Chapel*

PO Box 1256 Hwy. 28 North  
Anytown, Georgia 30632  
(706)555-5555

Services of Funeral Director and Staff 1950.00

Additional Services

Embalming 450.00  
(may not be required by law)  
Other care of deceased \_\_\_\_\_

Facilities for visitation  
1 nights at 185.00

Funeral Service: Church, Chapel, Graveside,  
Memorial, Other 1675.00

Use of facilities And equipment 365.00

Equipment for ceremony  
Elsewhere (Residence) \_\_\_\_\_

Other \_\_\_\_\_

Transfer of body 65.00

Funeral Coach 295.00

Family Car 295.00  
Other Automotive  
Equipment, Utility, Flower Van 60.00

Other \_\_\_\_\_

TOTAL  
Professional Services 5340.00

MERCHANDISE as selected  
Casket 14,500.00

Vault 2450.00  
Alternative outside  
Enclosure \_\_\_\_\_

Clothing 50.00

Urn Sales \_\_\_\_\_

Acknowledgement cards 195.00

Register book 65.00

Other memorial supplies \_\_\_\_\_

TOTAL  
MERCHANDISE 17,260.00

ITEMS INVOLVING  
CASE ADVANCES  
To permit us to render a better services we have  
Advanced the money on these for your convenience. We  
charge for our services in buying these items.  
OTHER SERVICES  
PROVIDED

Obituary Notices

One town 20.00

Second town \_\_\_\_\_

Third town \_\_\_\_\_

Other \_\_\_\_\_

Additional Mileage  
(Auto) \_\_\_\_\_

Cemetery Charges 350.00

Grave Equipment \_\_\_\_\_

Sales Tax ( 7% ) 1582.00

Extra Cemetery Charge \_\_\_\_\_

Cremation \_\_\_\_\_

Transportation \_\_\_\_\_

Long Distance Calls 10.00

Clergy 200.00

Music 90.00

Flowers 80.00

Beautician 25.00

Death Certificates ( ) \_\_\_\_\_

Other Funeral Home \_\_\_\_\_

Airline Transportation \_\_\_\_\_

Other \_\_\_\_\_

TOTAL CASH  
ADVANCES 2357.00

**SUMMARY OF CHARGES**

- (1) Professional Services .....\$ 5340.00
  - (2) Merchandise.....\$ 17,260.00
  - (3) Other Services Provided.....\$ 2357.00  
Cash Advances
- TOTAL (1,2,3) \$ 24,957.00
- (4) items ordered later  
Both parties agree any items ordered  
Later shall become a part of this  
Agreement and shall be inserted  
Herein
- TOTAL (1,2,3,4) \$ 24,957.00

SERVICE MERCHANDISE DISCOUNT OF \_\_\_\_\_ IF SERVICES ARE PAID IN FULL  
BY \_\_\_\_\_

In consideration of the services, merchandise and cash advances set forth above, the undersigned, jointly and severally,

promise to pay to the order of Norris FH the sum of \$24,957.00 under the following terms Paid in full on date of purchase

This is a cash transaction and penalty of \_\_\_\_\_% per month on the unpaid balance for unanticipated late payment may be charged effective the first day of the month following the due date. In the event of default, we agree to pay all costs of collection including reasonable attorney fees.

George Rogers s.s. # XXX-XX-XXXX

Signature of Purchaser

23 Bails St Fayetteville GA 30632  
Address City State Zip code

Signature of Co-signer with Purchase Address

The above purchaser/signee who represents hereby that he/she has legal authority and doing so hereby requests Norris Funeral Home and/or agents, employees to embalm the above name deceased individual in accordance with customary funeral and embalming procedures and practices, and/or remove all necessary medical devices.

LEGAL CEMETERY OR CREMATORY REQUIREMENTS COMPELLING THE PURCHASE OF ANY ITEMS EXPLAINED Cemetery requires embalming

REASON FOR EMBALMING EXPLAINED: Cemetery requirement

Open Casket requested by above purchaser signature, visitation, health, out of state

We agree to furnish all services, merchandise and cash expenditures indicated above but we MAKE NO WARRANTY OF FITNESS OR MERCHANTABILITY of the merchandise expressed or implied. The only warranties available, if any, are the expressed written warranties of the manufactures of the merchandise.

By Carol Norris, Owner

PERRY FUNERAL CHAPEL, INC.  
 P. O. BOX 687  
 301 McLENDON ST.  
 ASHBURN, GEORGIA 31714  
 229/567-3366

Ashburn, Turner Co., Georgia

The following agreement represents itemized charges of the merchandise selected for the funeral  
 Of Bernice Thomas SS# \_\_\_\_\_

This Contact is itemized in two separate sections. This contact only guarantees prices IF all charges are PAID IN FULL at the time this contract is made. IF not paid in full at the time the contact is signed, this contact DOES NOT guarantee any prices listed nor lock in any totals for future purposes. We reserve the right to adjust our prices at any time based on prices prevailing at the time of need.

Itemized Bill of Goods (This side has no ceiling)	Itemized Bill of Services (This side not to exceed \$10,000.00)
Casket/Urn \$ <u>4,613.00</u> ✓	Basic Service Fee \$ <u>1,726.00</u>
Vault \$ <u>2,556.00</u> ✓	Removal \$ <u>195.00</u>
Cemetery Equip. for Vault \$ <u>179.00</u> ✓	Embalming/Cosmo. \$ <u>770.00</u>
Open/Close Grave \$ <u>475.00</u> ✓	Visitation \$ <u>319.00</u>
Monumental Work \$ <u>2,946.00</u> ✓	Chapel/Church Serv. \$ <u>435.00</u>
Miscellaneous \$ <u>304.00</u>	Service Vehicles \$ <u>407.00</u>
Misc. Cemetery Work \$ _____	Mem./Sundry Pkg. \$ _____
Sales Taxes \$ <u>729.33</u>	Cremation Fee \$ _____
TOTAL \$ <u>11,802.33</u>	TOTAL \$ <u>3,852.00</u>

TOTAL OF ALL CHARGES  
 \$ 15,654.33

**Paid In Full**

- Copies of Insurance Policy attached to this agreement represents monies invested for payment of the above burial of Bernice Thomas.
- I, Bernice Thomas do hereby understand that any interest made from monies invested are reinvested in the face amount to aid in payment of inflation increases.
- I, Bernice Thomas approve these charges and fully understand that these charges for merchandise/services are good for sixty days from date of this agreement, and DO NOT include any additional charges as may be needed or desired at the time of death of Bernice Thomas.
- I, Bernice Thomas and Perry Funeral Chapel, Inc., both fully understand that if the monies set aside under this contract are withdrawn from any reason, or interest is not reinvested in the face amount, this contract is null and void.
- Perry Funeral Chapel, Inc. acknowledges that funds have been set aside as noted in item number one for the burial expenses of and acknowledge that Bernice Thomas has the rights to this merchandise and is being held for Bernice Thomas by Perry Funeral Chapel, Inc.

DATED THIS 25 DAY OF Jan., 2008

Bernice Thomas

Relationship \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

[Signature]  
 Perry Funeral Chapel, Inc.

TITLE [Signature]

301 McLendon Street., Ashburn, Georgia 31714



Money or Support provided to the client—

<b>IF</b>	<b>THEN</b>
Money is given to the client	This is income, regardless of how the money is to be spent or what the COA
A bill is paid for the client	Look at the COA
COA is QMB, SLMB, QI-I or LA-D	This is excluded income—this is called a vendor payment
COA is an FBR type or Medically Needy	Look at what expense is being paid
COA is FBR or Medically Needy and the expense is food, mortgage (including tax and insurance), rent, heating fuel, gas, electricity, water, sewer, or garbage removal	This is potentially In-Kind Support and Maintenance (ISM)
COA is FBR or Medically Needy and the expense is not listed above	This is excluded income—this is called a vendor payment

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INCOME TYPE	HOW IS THIS RESOURCE USUALLY VERIFIED?	POLICY MANUAL SECTION	NOTES
RSDI	Usually through a TPQY or BENDEX, may get an award letter	2499	Don't ask the client for verification if you can get it yourself
Pension			
Retirement Income			
Contributions			
Wages			
VA Income			

**Printed material for Financial Eligibility Course Current as of January 2019  
Georgia Application for Medicaid & Medicare Savings for Qualified Beneficiaries**

(QMB - payment of premiums, coinsurance, and deductibles;  
SLMB - payment of Part B premium; and QI-1 - payment of Part B premium)

**INSTRUCTIONS:**

1. Read the application carefully & answer each question accurately. ~~Attach additional pages if needed~~
  2. **Sign and mail application to:** \_\_\_\_\_  
(Mail or deliver application to the DFCS office in your county of residence) \_\_\_\_\_  
\_\_\_\_\_
- RECEIVED IN COUNTY 10/2/XX
- ATTN: \_\_\_\_\_
3. A telephone interview may be required for these programs. Be sure to enter phone # below.
  4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

**PERSONAL INFORMATION: You may have someone help you complete this application.**

Applicant's Name (Last, First, Middle Initial) <b>MATTHEWS, BRIAN</b>	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial) <b>Caring Arms, Inc.</b>
Mailing Address	Mailing Address <b>9658 N. Main Street</b>
Street Address <b>785 JERRLINN PARK</b>	Mailing Address <b>9658 N. Main Street</b>
City <b>FAYETTEVILLE</b> State <b>GA</b> Zip <b>30288</b>	City <b>Fayetteville</b> State <b>GA</b> Zip <b>30288</b>
Do you own/are you purchasing home? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N	
Phone <b>4045555555</b> County	Phone <b>7705555555</b>
E-Mail Address	E-Mail Address
Nursing Facility (if applicable)	Relationship to Individual <b>Hospice provider</b>

**COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.**

Name (Self): <b>BRIAN</b>	Birthdate <b>05/14/59</b>	Sex <b>M</b>	Race <b>B</b>	U.S. Citizen (Yes or No) <b>YES</b>	Social Security Number <b>89803XXXX</b>	Marital Status <b>SINGLE</b>
Maiden/other name(s):						
Name (Spouse):						
Maiden/other name(s):						

Are you applying for your spouse, too?  Yes  No

Are you blind or disabled?  Yes  No - Is your spouse blind or disabled?  Yes  No

**LIVING ARRANGEMENT: Check the box(es) that best describes your current situation.**

Living In Own Home	Nursing Facility	Another's Home	Hospice	Hospital	Katie Beckett	Community Care	Assisted Living	Other
<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>					
Date Admitted:	Date Admitted:	Date Admitted:	Date Admitted:	Date Admitted:	Date Admitted:	Date Admitted:	Date Admitted:	Date Admitted:
<b>XX</b>			<b>XX</b>					



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**RESOURCES:** Check all resources (assets) owned by you, your spouse, or jointly owned with someone else. Include any accounts or properties on which your name(s) appear. Attach additional pages if necessary.

Do you or your spouse have any of the following resources?					
Checking account	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Funeral plans/ prepaid burial item	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Savings account	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Burial plots or contracts	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Government bonds	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Stocks and bonds	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Trust funds	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Other (IRA, CD, promissory note, etc.)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Have you or your spouse given away any assets for less than its value?				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.
<i>CHECKING ACCOUNT</i>		<i>102.00</i>	<i>BANK OF AMERICA</i>
<i>SAVINGS ACCOUNT</i>		<i>43.00</i>	<i>BANK OF AMERICA</i>

Do you or your spouse have a life insurance policy?  Yes  No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
<i>Brian</i>	<i>American General</i>		<i>10000.00</i>	<i>0</i>

**INCOME AND EARNINGS:** List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

- |                               |                           |                               |
|-------------------------------|---------------------------|-------------------------------|
| Social Security               | SSI                       | Wages/ Self-Employment        |
| Railroad Retirement Benefits  | Veterans' Benefits        | Trust or Annuity Payments     |
| Pensions/ Retirement Benefits | Rental Income Paid to You | Oil Royalties/ Mineral Rights |

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)
<i>Brian</i>	<i>Social Security</i>		<i>\$1420</i>	<i>Month</i>	<i>89803XXXX A</i>

Are you a veteran?  Yes  No Is your spouse a veteran?  Yes  No

Where did you and spouse work in the past? *Owens Corning Fiberglass*

Do you or your spouse have any unpaid medical bills ?  Yes  No

**PRIVACY STATEMENT:**

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

**ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:**

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) **As a condition of my eligibility, I agree to assign to the State all rights to medical support and to payment for medical care from any third party (hospital and medical benefits).** I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

**APPLICANT’S STATEMENT OF UNDERSTANDING AND AGREEMENT:**

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose.

I understand that Medicaid members who, are an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other mental institution that have their medical care paid by Medicaid will be subject to the Medicaid Estate Recovery Program. Additionally, Medicaid members who are 55 years of age or older and who receive home and community based services or are enrolled in and receive services through a waiver program are also subject to Estate Recovery.

I certify that I (or if filing for my spouse, my spouse and I) am a U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

**APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:**

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

<b>Signature of Applicant or Representative:</b> <i>Briax Matthews</i>	<b>Date:</b> <i>9/29/XX</i>
<b>Signature of Applicant’s Spouse or Representative:</b>	<b>Date:</b>

**DECLARATION OF CITIZENSHIP/ALIEN STATUS**

Georgia Department of Human Resources  
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the United States Department of Homeland Security (DHS) of my/my children’s citizenship or alien status when seeking benefits. Information received from DHS may affect my/my children’s eligibility.

Please fill out and sign **ONE or BOTH** of the following statements as it pertains to the status of each person seeking benefits.

**CHILDREN SEEKING BENEFITS**

Name	Place of Birth(city,state,country)	U.S. Citizen Immigrant (check whichever applies)	Lawfully Admitted	Date Naturalized or Admitted into U.S. (If applicable)

I, \_\_\_\_\_ attest to the identity of the child/children listed above and  
(PRINT NAME)  
certify under penalty of perjury, that the information written and checked above is true.

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)

**ADULT(S) SEEKING BENEFITS**

Name	Place of Birth(city,state,country)	U.S. Citizen Immigrant (check whichever applies)	Lawfully Admitted	Date Naturalized or Admitted into U.S. (If applicable)
<i>Brian Matthews</i>	<i>Fayetteville, GA US</i>	<i>YES</i>		

I, *Brian Matthews* certify under penalty of perjury, that the information  
(PRINT NAME)  
written and checked above is true.

*Brian Matthews*  
SIGNATURE (PARENT/GUARDIAN)

*10/2/XX*  
(DATE)

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)

**HOSPICE CARE COMMUNICATOR**

TO/FROM: Caring Arms, Inc. (hospice care agency)  
(circle one) Our Medicaid provider # is \_\_\_\_\_

TO/FROM: Fayette County DFCS (county DFCS office)  
(circle one)

RE: Brian Matthews 785 Jerlinn Park Fayetteville, GA  
(patient name) (patient address)  
89803XXXX 5/14/1959  
(Social Security number) (date of birth)

**Section I (to be completed by hospice care agency)**

- The above-named patient elects to receive hospice care services beginning 9/16/XX. The certification period extends from 9/16/XX through 12/15/XX.
- The above-named patient revokes hospice care or is otherwise discharged from hospice care effective \_\_\_\_\_. Destination \_\_\_\_\_.
- The patient's doctor certified on \_\_\_\_\_ that the patient's life expectancy is anticipated to be six months or less.
- The patient is admitted to hospice care in a nursing home as of \_\_\_\_\_.
- The patient is discharged from hospice care in a nursing home as of \_\_\_\_\_.

Mary Hill 9/16/XX  
(signature of Director) (date)

**Section II (to be completed by county DFCS office)**

- The above-named patient has been determined Medicaid eligible effective \_\_\_\_\_, and the Medicaid ID# is \_\_\_\_\_.
- The above-named has been denied/terminated Medicaid effective \_\_\_\_\_.
- Since this patient is admitted to hospice care in a nursing home, the monthly patient liability amount is \$ \_\_\_\_\_, effective \_\_\_\_\_.
- The monthly patient liability amount is changed to \$ \_\_\_\_\_, effective \_\_\_\_\_, and \$ \_\_\_\_\_, effective \_\_\_\_\_.
- Other: \_\_\_\_\_

\_\_\_\_\_  
(signature of caseworker) (date)

# **DESK GUIDE**

## **How to set up a Qualified Income Trust**

**QUALIFIED INCOME TRUSTS**

**Manual Section 2407**

LA-D A/Rs whose income is equal to or greater than the Medicaid Cap may establish a Qualified Income Trust QIT as an alternative by which they may receive Medicaid benefits by sheltering all or a portion of their income from the eligibility determination process.

To establish a QIT, the applicant must:

- Complete and sign a QIT legal document.
- Open a separate account (usually a checking account) to use for the QIT.
- Deposit enough income into the QIT account so their remaining income is below the Medicaid Cap amount.
- Use the income in the QIT only for the four expenses listed on the QIT Worksheet.

We will:

- Not count the money in the QIT account when we determine their eligibility.
- Review the account every six months to be sure the correct amount is being deposited into the account and only allowed expenses are being paid from the account. One of the reviews may coincide with the annual review.

**Printed material for Financial Eligibility Course Current as of January 2019**  
**Steps to setting up a Qualified Income Trust**

**Step 1:**

Upon receipt of LA-D application, promptly review income listed on application to determine if QIT will need to be established.

**Step 2:**

BEFORE speaking with the AR, put together a packet including:

- The Guide for Trustees
- QIT Worksheet
- The template
- Certification page

Complete the worksheet to determine the amount the AR will need to deposit in a QIT to be eligible. Review the information on the worksheet and guide.

**Step 3:**

In speaking with the AR, paraphrase the information on the worksheet.

Be sure the AR (or PR) understands that the QIT must be set up AND funded for the AR to be eligible. Give an example, such as "If you need Medicaid for November, the QIT must be set up and funded by November 30<sup>th</sup>."

Assure AR (or PR) that it is not necessary to hire a lawyer to set up the QIT. You will send a "fill in the blank" template for completion.

**Step 4:**

Send or take all the QIT forms to the AR/PR.

On the verification checklist, indicate that you need the template, the certification page, the information about the account they set up, and proof of the date and amount of the first deposit.

**Step 5:**

When you receive the information from the AR/PR:

Review the template and make sure no changes were made to the template. If changes were made or the template not used, the QIT must be sent to DCH Legal Services Section for approval.

Be sure the certification page is signed.

Check the date and amount of the first deposit.

Send a copy of the QIT with a Form DMA 285 to **TPL/DCH. – P O Box 38439, Atlanta, GA 30334**. If an individual other than the AR signed the QIT template, also include the legal document that assigns Power of Attorney.

Document the information about the QIT in GA Gateway.

Continue with the eligibility process, do not approve an LA-D type for any month the QIT was not funded.

**Example Case  
Setting Up a Qualified Income Trust**



Mrs. Francis Christopher is entering a nursing home. Her resources are below the allowable resource amount, but her income is above the income limit for nursing home Medicaid. She receives \$1800 RSDI and \$2200 Retirement.

Total income is \$4000/month. Her income is greater than the Medicaid Cap amount of \$2349.

**Step 1:**

Copies of the following forms (from the policy manual Forms Section) are provided to Mrs. Christopher:

- The Guide for Trustees
- QIT Worksheet
- The template
- Certification page

The worksheet is completed to determine the amount Mrs. Christopher will need to deposit in a QIT to be eligible.



**Printed material for Financial Eligibility Course Current as of January 2019**  
**QUALIFIED INCOME TRUST (QIT) WORKSHEET**

<u>Income Source</u>	<u>Monthly Gross Amount</u>
Social Security	<u>1800</u>
State Retirement	<u>                    </u>
V.A. Pension	<u>                    </u>
Other Pension	<u>2200</u>
Interest, Dividends	<u>                    </u>
Annuity	<u>                    </u>
Other	<u>                    </u>
<b>Total Monthly Income</b>	<u>4000</u>
Current Medicaid Cap - \$1.00	- <u>2348</u>
<b>Amount Over Cap*</b>	<u>1652</u>

**\*THIS IS THE MINIMUM AMOUNT THAT MUST BE DEPOSITED INTO THE QIT ACCOUNT EACH MONTH. HOWEVER, WE STRONGLY RECOMMEND THAT ALL OF THE INCOME BE DEPOSITED INTO THE QIT EACH MONTH. THIS WILL REDUCE THE PROBABILITY OF ERRORS. REMEMBER, FAILURE TO PROPERLY AND TIMELY FUND THE QIT WILL RESULT IN A LOSS OF ELIGIBILITY FOR THAT MONTH.**

Allowable QIT Disbursements	Amount
Patient Liability/Cost Share	\$ 3930
Personal Needs Allowance	\$ 70
Diversion to Spouse/Dependent Family Member	\$ 0
Incurred Medical Expense(s)	Any Medical Expense not covered by Medicaid.

Mrs. Christopher does not have a spouse in the home and she does not have any Incurred Medical Expenses. Her patient liability amount (what she will have to pay the nursing home each month) is \$3930/month. Her personal needs allowance amount is \$70/month.

NOTE: Patient liability budgeting is discussed in the LA-D course.

**Step 2:**



We discuss the Qualified Income Trust policy with Mrs. Christopher (or her personal representative).

In speaking with the Mrs. Christopher, we paraphrase the information on the worksheet.

“In order to receive Nursing Home Medicaid, you will need to set up a Qualified Income Trust.”

“This involves several steps—first, you must complete and sign a Qualified Income Trust template.”

“I will send you a template to complete. It is pretty straightforward and most people find that they are able to complete it without the assistance of an attorney. Once you have completed the template, you must sign it and have a witness verify your signature. Only you can sign the template, your trustee or personal representation can NOT sign the template for you. If you’re unable to sign the template, someone must have Power Of Attorney to sign the template for you. Again, it cannot be the trustee.”

“In addition to signing the template, you must also sign the enclosed Certification form. This form indicates that you did not change the QIT in any way. Note that although the certification form asks for the “Bar Number”, this is only needed IF you use an attorney to complete the template for you. If you complete the template, just leave this line blank.”

“Once you have completed the template and the certification form, take the document to a bank. Open an account called the “Qualified Income Trust Account for Frances Christopher”. You may use any bank you choose. I know that some of my other clients have used XYZ Bank and ABC Bank, so if you have difficulty you may try one of those.”

“A couple of important things about the account—there cannot be any fees or charges accessed from the money in the account and you cannot direct deposit your RSDI or retirement check into the bank. Most people find it helpful to keep their regular account to have direct deposit, and set up a monthly transfer from the regular account to the QIT account.”

“You must deposit at least \$1979 in this account each month. Most people find it easier, though, to deposit the entire amount they will be paying the nursing home each month into the account. In your case, this would mean you would deposit \$3930/month into this account. This makes it a little easier because you only need write one check to the nursing home each month.”

**Printed material for Financial Eligibility Course Current as of January 2019**

“When you have finished setting up your account, please return to me the completed template, the signed certification form, and verification from the bank that you have set up and deposited money into the account.”

“Please understand, you will not be eligible for nursing home Medicaid until the account is set up AND FUNDED. So if you need Medicaid for November, the QIT must be set up and funded by November 30<sup>th</sup>.”

“I will send everything I’ve just told you in writing, along with a checklist for you to return the needed items.”

**Step 3:**

All of the QIT related items are mailed to Mrs. Christopher. They are accompanied by a verification checklist.

Example:

**XX Related to the QIT we discussed, I am enclosing a "Guide for Trustees" to help you understand the process for setting up and funding a QIT, a "Worksheet" that explains the minimum amount that must be deposited in the QIT account each month, the template, and a QIT certification page.**

**To establish eligibility, you must return:**

**One completed template**

**The signed "certification page"**

**Proof that you have opened an account for the QIT**

**Proof that you have deposited at least the minimum amount necessary in the QIT**

**PLEASE NOTE: THE QIT MUST BE SET UP AND FUNDED BEFORE YOU CAN RECEIVE MEDICAID.**

**PLEASE CALL ME IF YOU HAVE QUESTIONS OR NEED HELP WITH ANYTHING I HAVE ASKED YOU TO DO.**

**Step 4:**

Mrs. Christopher takes all the necessary steps and returns the necessary forms and verification.



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIXTH:** Termination. The trust shall cease and terminate at the death of the Beneficiary, or earlier if the Trustee determines that the existence of the trust is no longer necessary to establish Medicaid eligibility for the Beneficiary. Upon the termination of the trust, the remaining trust property, if any, shall be distributed as follows:

A. To the State of Georgia, if it has provided medical assistance to the Beneficiary up to an amount equal to the total medical assistance paid on behalf of the Beneficiary by Georgia's state plan for Medicaid assistance or other approved waiver programs; this provision is intended to meet the requirements of 42 U.S.C. 1396(p) as amended by OBRA '93.

B. Any remainder after the State of Georgia's claim has been paid, to the Beneficiary's heirs at law.

**SEVENTH:** Trustee's Powers. The Trustee shall have all of the powers that may be granted by law with respect to the trust, to be exercised in the Trustee's discretion, in accordance with the best interests of the Beneficiary.

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EIGHTH: Law to Govern; Construction. The construction of this instrument and the validity of the interest created hereby shall be governed by the laws of the State of Georgia. The administration of the trust shall be governed by the laws of the State of Georgia, or by the laws of any other state in which the trust may from time to time be administered.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

WITNESSES:

Signature: Francis Christopher, Settlor

Witness Signature: Mary Brown

Witness Print Name: Mary Brown

STATE OF GEORGIA

COUNTY OF Cobb SS: 252-98-XXXX

The foregoing instrument was acknowledged before me this 28th day of November, 2009 by Francis Christopher who is personally known to me or who produced GA Driver's License as identification, and who did not take an oath.

NOTARY PUBLIC, State of Georgia

Notary Signature Norma Evans

Print Name Norma Evans

My Commission Expires: 11/10/2012

My Commission Number: 12411-12

Printed material for Financial Eligibility Course Current as of January 2019  
SCHEDULE "A"

	<u>Source</u>	<u>Amount</u>
1.	<u>Social Security (gross)</u>	\$ <u>1800.00</u>
2.	<u>Pension (gross)</u>	\$ <u>2200.00</u>

Printed material for Financial Eligibility Course Current as of January 2019  
**CERTIFICATION OF DEPARTMENT OF COMMUNITY HEALTH APPROVED  
QUALIFIED INCOME TRUST**

I certify that the foregoing Qualified Income Trust of **Francis Christopher** is identical in all material respects to a Department of Community Health approved trust form. I have made no changes other than names, dates, and other identifying information.

11/28/09  
Date

Francis Christopher  
Signature  
Address: 2869 Bethel Park Road  
Marietta, GA 30325

State Bar No.: \_\_\_\_\_

# Bank of Austell

To: Cobb County DFCS  
7569 Cobb Parkway  
Marietta, GA 30365

From: Bank of Austell  
2847 Hwy 5 E  
Austell, GA 21045

November 28, 2009

This is to verify that Frances Christopher opened a checking account on 11/28/09 titled "The Francis Christopher Qualified Income Trust". The account number is 1421785417, there are no fees associated with this account.

Ms. Christopher and her daughter, Carol Robinson, are authorized to use the account.

An initial deposit of \$2000 was made on this date.

Please let us know if you need additional information.

Sincerely,

*Scott Marcus*

Scott Marcus  
Vice-President

At this point, we:

- Review the template and make sure no changes were made to the template. (If changes were made or the template not used, the QIT must be sent to DCH Legal Services for approval.)
- Be sure the certification page is signed.
- Check the date and amount of the first deposit.
- Send a copy of the QIT with a Form DMA 285 to **TPL/DCH. – P O Box 38439, Atlanta, GA 30334.**
- If a person with Power of Attorney signed the QIT, mail the Power of Attorney document as well.
- Document the information about the QIT in GA Gateway.
- Continue with the eligibility process. (Do not approve LA-D for any month the QIT was not set up and funded—it may be necessary to complete AMN for prior months.)

Appendix I (ESS Policy Manual) provides detailed Gateway instructions for coding the QIT information.

**INSTRUCTIONS:**

1. Read the application carefully & answer questions if needed.

*Application received 10/3/XX*

if

2. **Sign and mail application to:** \_\_\_\_\_

*ANY*

County DFCS

(Mail or deliver application to the DFCS office in your county of residence)

ATTN: \_\_\_\_\_

3. A telephone interview may be required for these programs. Be sure to enter phone # below.

4. The DFCS Medicaid Specialist will review this application. If it appears that you may be eligible for full Medicaid coverage, the Medicaid Specialist will contact you for more information and verifications.

**PERSONAL INFORMATION:** You may have someone help you complete this application.

Applicant's Name (Last, First, Middle Initial) <i>HONG, THOMAS</i>	If you wish to name a person to act on your behalf, complete the information below: Name (Last, First, Middle Initial) <i>HONG, POLLY</i>
Mailing Address <i>BAYVIEW NURSING HOME</i>	Mailing Address <i>785 HARRIS STREET SW</i>
Street Address <i>145 W CLEVELAND STREET</i>	City <i>RICHLAND</i> State <i>GA</i> Zip <i>30265</i>
City <i>NAHUNTA</i> State <i>GA</i> Zip <i>31553</i>	Do you own/are you purchasing home? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Phone <i>404-555-5555</i> County _____	Phone <i>770-523-6987</i>
E-Mail Address _____	E-Mail Address _____
Nursing Facility (if applicable) <i>BAYVIEW</i>	Relationship to Individual <i>SPOUSE</i>

**COMPLETE THIS INFORMATION FOR YOU AND YOUR SPOUSE.**

Name (Self):	Birthdate	Sex	Race	U.S. Citizen (Yes or No)	Social Security Number	Marital Status
<i>THOMAS HONG</i>	<i>4/9/1920</i>	<i>M</i>	<i>AS</i>	<i>YES</i>	<i>999-99-XXXX</i>	<i>MARRIED</i>
Maiden/other name(s):						
Name (Spouse):	<i>8/7/1932</i>	<i>F</i>	<i>AS</i>	<i>YES</i>	<i>888-88-XXXX</i>	<i>MARRIED</i>
Maiden/other name(s):						

Are you applying for your spouse, too?

Yes

No

**LIVING ARRANGEMENT:** Check the box(es) that best describes your current situation.

Living In Own Home	Nursing Facility	Another's Home	Hospice	Hospital	Katie Beckett	Community Care	Assisted Living	Other
	Date Admitted: <i>9/30/XX</i>			Date Admitted:		Date Admitted:		



Do you or your spouse have any of the following resources?

Checking account	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Funeral plans/ prepaid burial item	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Savings account	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Burial plots or contracts	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Government bonds	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Stocks and bonds	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Trust funds	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Other (IRA, CD, promissory note, etc.)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Have you or your spouse given away any assets for less than its value?				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.
CHECKING ACCOUNT	1984625-684	\$846	BANK OF AMERICA
SAVINGS	12541-8962	\$5000	BANK OF AMERICA

Do you or your spouse have a life insurance policy?  Yes  No

If yes, please complete the following information. Attach additional pages if necessary.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
THOMAS	PRUDENTIAL	125412	\$25000	0
POLLY	PRUDENTIAL	1547896	\$10000	250

**INCOME AND EARNINGS:** List all types of earnings and income that you and your spouse receives. List the income amount before deductions (such as taxes, insurance, or Medicare premiums) are taken out. Attach additional pages if needed. Income includes, but is not limited to:

- Social Security
- Railroad Retirement Benefits
- Pensions/ Retirement Benefits
- SSI
- Veterans' Benefits
- Rental Income Paid to You
- Wages/ Self-Employment
- Trust or Annuity Payments
- Oil Royalties/ Mineral Rights

Name of Person Who Receives Income	Type of Income	Source of Income or Name of Employer	Amount	How Often Received? (weekly, monthly, etc.)	Claim Number (if applicable)
THOMAS	RSDI		\$1700	MONTH	88888XXXX
POLLY	RSDI		\$1400	MONTH	99999XXXX

Are you a veteran?  Yes  No Is your spouse a veteran?  Yes  No

Where did you and spouse work in the past? Self Employed

Do you or your spouse have any unpaid medical bills?  Yes  No

**PRIVACY STATEMENT:**

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

**ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:**

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) **As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party.** I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

**APPLICANT’S STATEMENT OF UNDERSTANDING AND AGREEMENT:**

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose.

I understand that Medicaid members who, are an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other mental institution that have their medical care paid by Medicaid will be subject to the Medicaid Estate Recovery Program. Additionally, Medicaid members who are 55 years of age or older and who receive home and community based services or are enrolled in and receive services through a waiver program are also subject to Estate Recovery.

I certify that I (or if filing for my spouse, my spouse and I) am a U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

**APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:**

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

<b>Signature of Applicant or Representative:</b> <i>Thomas Hong</i>	<b>Date:</b> <i>9/30/xx</i>
<b>Signature of Applicant’s Spouse or Representative:</b>	<b>Date:</b>

**DECLARATION OF CITIZENSHIP/ALIEN STATUS**

Georgia Department of Human Resources  
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the United States Department of Homeland Security (DHS) of my/my children's citizenship or alien status when seeking benefits. Information received from DHS may affect my/my children's eligibility.

Please fill out and sign **ONE or BOTH** of the following statements as it pertains to the status of each person seeking benefits.

**CHILDREN SEEKING BENEFITS**

Name	Place of Birth(city,state,country)	U.S. Citizen Immigrant (check whichever applies)	Lawfully Admitted	Date Naturalized or Admitted into U.S. (If applicable)

I, \_\_\_\_\_ attest to the identity of the child/children listed above and  
(PRINT NAME)  
certify under penalty of perjury, that the information written and checked above is true.

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)

**ADULT(S) SEEKING BENEFITS**

Name	Place of Birth(city,state,country)	U.S. Citizen Immigrant (check whichever applies)	Lawfully Admitted	Date Naturalized or Admitted into U.S. (If applicable)
<i>THOMAS HONG</i>	<i>KYOTO, JAPAN</i>	<i>XX</i>		<i>2/25/1932</i>

I, *Thomas Hong* certify under penalty of perjury, that the information  
(PRINT NAME)  
written and checked above is true.

*Thomas Hong*


\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

*9/30/xx*

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)



**MEDICARE HEALTH INSURANCE**

Name/Nombre  
**Thomas Hong**

Medicare Number/Número de Medicare  
**XXXXX1234A**

Entitled to/Con derecho a	Coverage starts/Cobertura empieza
<b>PART A</b>	<b>4-1985</b>
<b>PART B</b>	<b>4-1985</b>

**AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT**

DATE OF RECEIPT

FOR DMA USE ONLY



**SECTION I - IDENTIFICATION**

NAME OF FACILITY <b>BAYVIEW NH</b>		CITY <b>BRANTLEY</b>	MEDICAID PROVIDER NO. <b>000624951A</b>	SOCIAL SECURITY NO. <b>8 8 8 8 8 X X X X</b>
RECIPIENT'S NAME <b>THOMAS HONG</b>		RECIPIENT'S MEDICAID NO. <input type="text"/>	PRIMARY ICD-9-CM <b>401.9</b>	SECONDARY ICD-9-CM <input type="text"/>
		DATE OF BIRTH <b>0 4 0 9 2 0</b>		

**SECTION II - ADMISSION**

LEVEL OF CARE <b>1</b> 1-Skilled 2-IC 3-IC/MR	PATIENT ADMITTED FROM: <b>D</b> A-Hospital B-Nursing Facility (NF) C-State Instit. D-Own Home E-Other F-SNF Medicare	ADMISSION DATE <b>0 9 3 0 X X</b>	VA AID & ATTENDANCE INCLUDED: ( ) Yes \$ _____ ( ) No	DMA-6 ATTACHED: ( ) Yes ( ) No	QMB ELIGIBLE: ( ) Yes ( ) No	PAYMENT EFFECTIVE DATES: M M D D Y Y	PATIENT INCOME:
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**SECTION III - STATUS CHANGES**

NEW LEVEL OF CARE <input type="text"/> 1-Skilled 2-IC 3-IC/MR	LOC EFFECTIVE DATE: M M D D Y Y	VA AID & ATTENDANCE INCLUDED: ( ) Yes \$ _____ ( ) No	DMA-6 ATTACHED: ( ) Yes ( ) No	QMB ELIGIBLE: ( ) Yes ( ) No	PAYMENT EFFECTIVE DATES: M M D D Y Y	PATIENT INCOME:
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**SECTION IV - TERMINATIONS**

REASON: <input type="text"/> E-INELIGIBLE F-DISCHARGED G-DIED	EFFECTIVE DATE: M M D D Y Y	DISCHARGE DESTINATION: <input type="text"/> A-Home with a Health Plan B-Hospital C-Nursing Facility (NF) D-Other	E-Own Home F-SNF Medicare L-Limited Stay Expired
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**SECTION V - FACILITY CERTIFICATION**

I do hereby certify that the above statements are true and correct. I agree to submit to the County Department a status change request for any change in the monthly contributions by the recipient.

Signature of Facility Administrator X Frances McDermott DATE: **1 0 0 2 X X**

**SECTION VI - AUTHORIZATION**

Signature of Assistance Payments Worker X \_\_\_\_\_ County Code  DATE: