



Georgia Department of Human Resources
Medicaid Addendum



Please answer the following questions if you are applying for Medicaid

1. If you are an adult applying for Medicaid for your dependent child(ren), do you want to receive Medicaid for yourself?

- Yes No

2. Do you have other health insurance that covers anyone in the household?

- Yes No

3. Does your spouse have other health insurance?

- Yes No

If you answered yes to questions 2 and/or 3 above, please complete the following information:

	Health Insurance Company Name, Address and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical)	Name of Persons Covered	Effective Date	Policy Number
Self					
Spouse					

4. Are you or your spouse currently covered by Medicare?

- Yes No

5. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?

- Yes No Date of SSI application: _____

6. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?

- Yes No

7. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?

- Yes No

8. Are you applying for Medicaid to help pay for community based waiver services such as Community Care Services, Mental Retardation Waiver, Hospice Care, Independent Care Waiver or the Deeming Waiver (Katie Beckett)?

- Yes No

Resources: Check all resources (assets) owned by you, your spouse, your dependents or jointly owned with someone else. Attach additional pages if necessary.

- Checking Accounts Yes No Funeral Plans/Prepaid Burial Item Yes No
 Savings Accounts Yes No Burial Plots or Contracts Yes No
 Government Bonds Yes No Stocks and Bonds Yes No
 Trust Funds Yes No Other (IRA, CD, etc.) Yes No
 Real Property/Homeplace Property Yes No
 Have you or your spouse given away any assets for less than its value? Yes No

If you answered yes to any of these questions, please describe below.

Type of Resource	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.

Does anyone in the household own a vehicle? If so, please describe below. Yes No

Vehicle Make	Model	Year	Amount Owed

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

If yes, please complete the following information.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

Income and Earnings: List all types of earnings and income that your household receives. List the income amount before deductions such as taxes, insurance or Medicare premiums are taken out.

Income Type	Gross amount	How often? (weekly, every 2 weeks, monthly, etc.)	Name of Person Receiving
Wages/Salary			
Current Employer:			
Wages/Salary			
Current Employer:			
Unemployment Benefits			
Social Security Income			
SSI			
Worker's Compensation			
Pension/Retirement Benefits			
Veterans Benefits			
Child Support			
Contributions			
Other Income (please specify)			