GEORGIA DEPARTMENT OF HUMAN SERVICES

Medicaid and IV-E Redetermination Form

This form is to be completed by JPPS upon notification from the Regional Eligibility Specialist. The form is used to establish continuing eligibility.

Youth's Name: _____ Youth's Medicaid Member ID # (12-digits):_____

Date of Birth: _____ Month Review Due: _____

Date Youth Detained/Placed: _____ Joint DJJ/DFCS Custody: _____ yes _____ no

1. Current Placement name/address: _____

   _____

   Indicate type of placement: _____ Child Caring Institution _____ Child Placing Agency _____ A&D _____ RYDC

   _____ Wilderness _____ PRTF _____ Other (specify) _____

2. Does youth remain committed to DJJ? ___ yes ___ no
   Date of commitment order: _____
   Expiration date of current commitment: _____
   If not committed, please explain_____

3. What is the youth's monthly income? _____
   ___ Earned ___ Unearned Source of Income: _____

4. Are there any changes to the youth's resources? ___yes ___no Value of Resources: _____

5. Is the youth covered by health insurance other than Medicaid/PeachCare? ___yes ___no
   If yes, name of insurance company:_____
   Group/ID #:_____
   Name of insured: _____Relationship to youth: _____
   (Please e-mail/fax copy of front and back of insurance card)

JPPS Signature: _____ Date:_____

Eligibility Specialist Signature: _____ Date Received: _____