DFCS - FAYETTE CNTY
PO BOX 4147
ATLANTA GA 30302

1-877-423-4746

DEPARTMENT OF HUMAN SERVICES
DEPARTMENT OF COMMUNITY HEALTH
DEPARTMENT OF PUBLIC HEALTH
DEPARTMENT OF EARLY CARE AND LEARNING

REVIEW RESULTS

Worker ID: 864939
Worker Name: J.Bottex
Worker Phone Number: (470) 532-0474
Case Number: 123286953
Client ID: 854006737

ZAKENYA WILLIAMS
215 MEADOWBROOK CT APT A
FAYETTEVILLE GA 30215 -8282

DATE: 01/02/2024

Report Medicaid Fraud: 1-800-533-0686

Dear ZAKENYA WILLIAMS,

Medical Assistance

Application Date: 01/02/2024

Benefit Period	Person(s)	Decision	Program Information
01/01/2024 - 01/31/2025	ZAKENYA WILLIAMS	Approval	**Program:** Family Planning Services See **Medical Assistance Information** section below

Medical Assistance Information

Planning for Healthy Babies®

Thank you for returning your Planning for Healthy Babies® (P4HB) Renewal papers. You have completed your renewal process and remain eligible for P4HB services. You must always remain eligible to continue receiving P4HB services.

What if my situation changes?

If your situation changes, you must tell us within ten (10) business days. Changes that you need to tell us about include:

- New phone number
- New address
- If your family or household size changes
- If you become pregnant
- If you are no longer able to have a baby
- If you get a job or a pay raise
- If you begin to receive any new income

- If you get private insurance

To tell us about the change, call 1-877-423-4746, or fax to 1-888-744-2102 or mail to the address below.

What if my income changes?

If your income changes, you must send in proof of your income using one paper from this list:

- Most recent consecutive month's pay stubs in a row showing gross income.
- Letter from your employer. The letter must state gross income and how often you get it. An officer of the company must sign and date the letter.
- Unemployment Check, Compensation Letter or letter stating how much Unearned Income you get and how often you get it.

You must report your changes within ten (10) days. If you are not sure you must report the change, contact P4HB and we will let you know if you are required to report this change.

You will be given time to provide proof of all income changes. If you need assistance with obtaining this proof please contact P4HB.

How do I send in my new changes?

By fax: 1-912-632-0389

By mail: Planning for Healthy Babies®
P.O. Box 786, Alma, GA 31510

Important: Write your Account Number on all pages.

What if I have questions?

We can answer your questions. Call us at 1-877-423-4746.The call is free.
You or someone in your household is still eligible for Medical Assistance. People approved for Medical Assistance will continue to get coverage through the last day of 01/31/2025 unless there is a change in their situation or regulations. We will send you another letter the month before this period ends telling you what to do to keep getting Medical Assistance.

If you have a Medicaid Spenddown case, Medicaid will only pay for your medical care after your Spenddown is met in a month. A "Spenddown" is the amount of your income you must pay on 01/31/2025 medical bills you are responsible for paying.

The information listed below helped us make our decision.

Medicaid- Family Planning Services	ZAKENYA WILLIAMS
We understand that you live	At Home
You requested assistance for this many people	1
Paycheck amounts per month (before taxes)	$ 1110.68
Net Countable Income Used	$ 1111.00
Income Limit for HH size	$ 2564.00

REPORTING CHANGES:

You must report changes in the following situations:

During your P4HB services, if your situation changes, you must tell us within ten business days. Changes that you need to tell us about include:

- New phone number
- New address
- If your family or household size changes
- If you become pregnant
- If you are no longer able to have a baby
- If you get a job or a pay raise
- If you begin to receive any new income
- If you get private insurance

What if my income changes?

If your income changes during your P4HB services, you must provide one of the documents from this list:

- Most recent consecutive pay stubs showing a month of gross income.
- Letter from your employer. The letter must state gross income and how often you get it. An officer of the company must sign and date the letter.
- Unemployment Check, Compensation Letter or letter stating how much Unearned Income you get and how often you get it.

How do I send in my new changes for P4HB?

By fax: 1-912-632-0389

By mail: Planning for Healthy Babies®
P.O. Box 786, Alma, GA 31510

Important: Write your Case Number on all pages

If you fail to report the required changes, you may have to repay any benefits you receive for which you were not eligible and you may also be prosecuted for fraud.

You may report changes, check the status of your benefits, and renew your benefits on-line at www.gateway.ga.gov. You may also report changes to your situation or get information about your benefits by phone at 1-877-423-4746.

Continuing Benefits

IMPORTANT INFORMATION:

- **Policy** used to determine your eligibility can be found at **http://odis.dhs.ga.gov/General.**
- In accordance with Section 504 of the **Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA)**, the **Department of Human Services (DHS)** provides Reasonable Modifications and Communication Assistance to persons with disabilities. More information can be found at Notice of ADA/Section 504 Rights, at https://dfcs.georgia.gov/adasection-504-and-civil-rights.
- In accordance with Federal laws and State policy, the **Department of Human Services (DHS)** is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, and in some cases religion or political beliefs.
- If you need help reading or completing this document or need help communicating with us, ask us or call

1-877-423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).

- Under the **Department of Human Services (DHS)**, you may file discrimination complaints by contacting your local DFCS office or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, 877-423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, 877-423-4746 (voice)

    - **30 days from the date of this notice for Medical Assistance.**

Planning for Healthy Babies® Right to Review

If you disagree with this decision, you may send a request for reconsideration to Planning for Healthy Babies® (P4HB). Your request for reconsideration must be received in writing within thirty (30) days from the date of the closure letter. A panel which consists of members from Right from the Start Medical (RSM) Assistance, and the Department of Community Health (DCH) will review your request for reconsideration and issue an Initial Determination. Please send your request for reconsideration to:

Planning for Healthy Babies® Resolution Coordinator
P.O. Box 786, Alma, GA 31510

Fax to:
1-912-632-0389

If you want to maintain your services pending the appeal process, you must send a written request before the date your services change. If the Department's determination is deemed correct, the agency may institute recovery procedures against you in order to recover the costs of any services provided to you.

This decision may be based in whole or in part on information contained in a consumer report. Such information may include employment or income verification provided by The Work Number, a service operated by the TALX Corporation (a provider of Equifax Verification Services, Equifax, Inc.) ("Consumer Reporting Agency"). Because the Consumer Reporting Agency did not make this decision, the Consumer Reporting Agency is unable to provide the specific reasons why this decision was made.

Under the Fair Credit Reporting Act ("FCRA"), 15 U.S.C. 1681 et seq., you have the right to dispute the accuracy or completeness of any information the Consumer Reporting Agency has provided by contacting them directly. Additionally, you have the right to obtain a free copy of a consumer report within sixty (60) days by contacting them directly. You may contact the Consumer Reporting Agency at Equifax Workforce Solutions, 3470 Rider Trail South, Earth City, MO 63045, 866-222-5880 (voice), 800-424-0253 (TTY).

If any of the information that was used to determine your eligibility is inaccurate, please inform us by reporting a change at www.gateway.ga.gov or contact us directly at 1-877-423-4746.

You may be able to get legal help at no cost. If you want a lawyer to help you, you may call one of the numbers below.

1. Georgia Legal Services Program
   1-800-498-9469
   (Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. Office of the State Long-Term Care Ombudsman
   Division of Aging Services
   2 Peachtree Street, NW, 32nd Floor, Atlanta, GA 30303-3142
   888-522-4464

3. Atlanta Legal Aid
   404-377-0701 (DeKalb County)
   678-407-6469 (Gwinnett County)
   770-528-2565 (Cobb County)
   404-524-5811 (Fulton County)
   404-669-0233 (So Fulton/Clayton County)

4. Georgia Senior Legal Hotline
   1-888-257-9519
   (Statewide legal services for elderly persons)

Where the sole issue involved is one of State policy, group hearings may be conducted 42 C.F.R. § 431.222.

FAIR HEARING REQUEST

Complete and return this form if you do not agree with this decision.

Today's Date:	**Telephone No.** (Where You can be Reached)

I am requesting a fair hearing for: ☐ **SNAP/Senior SNAP** ☐ **Medical Assistance** ☐ **TANF**

☐ **WIC**

By checking this box, I understand I am requesting a fair hearing because I disagree with the decision made on my request for SNAP/Senior SNAP, Medical Assistance, TANF, or WIC. I understand an administrative law judge will listen to the cases presented by both parties and will determine if state and federal law was followed correctly.

Please tell us why you want a fair hearing:

Check the correct box if applicable:

☐ I do not want to continue receiving the benefits I now receive while waiting for the hearing decision.

☐ I want to continue receiving the benefits I now receive while waiting for the decision. **I understand that I will be required to repay the Department of Human Services any overpayment in benefits to which I was not entitled as determined by the hearing official.** I understand that my benefits may not be continued if my case terminated at the end of a period of eligibility or if my application to receive benefits was denied.

_____ _____

Signature or Mark of Claimant Date

Please return this completed form to your County Department