OSAH FORM 1

(REPLACES DFCS FORM 166)

This form is available online at http://www.ganet.org/osah/form.html or by telephone request at (404)657-2800.

OSAH USE ONLY DOCKET NUMBER:	AGENCY DFCS	CASE CODE	DOCKET NUMBER	COUNTY	JUDGE

USE ONLY FOR THE MEDICAID PROGRAM (DFCS, not DCH Referrals)

Check One: ☐ Denial of Application ☐ Case Closure ☐ Reduction in Benefits ☐ Disputed Determination of Benefits
☐ Agency Inaction ☐ Failure to act within reasonable time for benefit change ☐ Denial of expedited services
☐ Denial of opportunity to apply for benefits ☐ Other: If so specify _____

CLAIMANT'S COUNTY OF RESIDENCE: _____ **Date Notice of Adverse Action Issued:** _____

DATE OFREQUEST FOR HEARING: _____

REGULATION(S) APPLIED: ☐ ESSM Manual Chapter(s) _____ Section(s) _____ ☐ ABD Manual Chapter(s) _____ Section(s) _____

Date DFCS received Claimant's Request for Hearing: ☐ Oral on _____ ☐ Written on _____

DFCS Case Number: _____ **BENEFIT CONTINUED PENDING APPEAL:** ☐ YES ☐ NO

TANF (ARM) OR LOW INCOME RELATED REFERRALS: SELECT ONLY ONE TYPE OF CASE

☐ 4MOCS (ESSM ' ' 831 & 830)	☐ LIMFE (Fin Eligibility: ESSM CHAPT 1200)	☐ STEP (Stepchild : ESSM ' 837)
☐ AAM1 (IV-E Adoption. , ESSM ' 805)	☐ LIMOM (Ongoing Mgt: ESSM CHAPT 1600)	☐ TLIM (TANF Medicaid: ESSM ' ' 801&810)
☐ CWFC (Welfare Foster : ESSM ' 840)	☐ MCM (Child of Minor: ESSM ' 836)	☐ TMA (Trans Med: ESSM ' 832 &830)
☐ EMA (Emergency Medical; , ESSM ' 866)	☐ NEWBORN (Medi Mom:ESSM ' 815)	☐ TNH (TANF N Home ESSM ' 803)
☐ FOST1 (ESSM ' 804)	☐ PEM (Presumptive Elig: ESSM ' 413)	☐ TRETRO (TANF Retroactive:ESSM ' 412,865)
☐ FOST2 (ESSM ' 805)	☐ PWCMN (Preg; ESSM ' ' 855, 856 &860)	☐ TRMA (Application: ESSM ' ' 410&411)
☐ LIMB (Budgeting: ESSM CHAPT 1400)	☐ RIBI (Ribicoff Child: ESSM ' 845)	☐ TRMAU (AU: ESSM ' 610)
☐ LIMBE (Basic Eligibility: ESSM CHAPT 1000)	☐ RSM (ESSM ' ' 820, 821 and 822)	☐ TUP (TANF Unemployed: ESSM ' 802)
☐ LIMBR (Benefit Recovery: ESSM CHAPT 2000)	☐ SAAM (State Adoption Assistant., ESSM ' 867)	☐ OTHER, specify_____
	☐ SFU (ESSM ' 850)	

AGED, BLIND OR DISABLED (ABD) REFERRALS SELECT ONLY ONE TYPE OF CASE

☐ ABDB (Elig. Budget.: ABD CHAPTER 1600)	☐ FSSIDC (ABD ' 616)	☐ QDWI (ABD ' 647)
☐ ABDBE (Basic Eligibility: ABD CHAPT 800)	☐ Hospice (ABD ' 635)	☐ QI1 (ABD ' 644)
☐ ABDCM (Case Mgt.: ABD CHAPTER 2200)	☐ Hospital (ABD ' 637)	☐ QI2 (ABD ' 646)
☐ ABDFR (Fin. Resp.: ABD CHAPTER 1200)	☐ KATIE (Deeming Waiver: ABD ' 633)	☐ QMB (ABD ' 643)
☐ ABDI (Income: ABD CHAPTER 1400)	☐ Laurens Head Inj. Waiver (ABD ' 638)	☐ SLMB (ABD ' 645)
☐ ABDL (Liability/Cost: ABD CHAPTER 1800)	☐ MRWP (ABD ' 632	☐ SSI (ABD ' 611)
☐ ABDR (Resources: ABD CHAPTER 1200)	☐ NH (ABD ' 641)	☐ WIDO1 (ABD ' 617)
☐ ABDRET (ABD Retro: ESSM ' ' 412 & 865	☐ PICKLE (ABD ' 613)	☐ WIDO2 (ABD ' 619)
☐ AMN (ABD ' 650)9 AMNNH (ABD ' 651)	☐ PROTEC (ABD ' 623)	☐ WIDO3 (ABD ' 621)
☐ DAC (ABD ' 615)		☐ OTHER, specify: _____

CLAIMANT

NAME:	TEL NO:	FAX NO:
CURRENT ADDRESS INCLUDING ZIP CODE:	EMAIL:	AMBULATORY? ☐ YES ☐ NO
ATTORNEY NAME:	TEL NO:	FAX NO:
ADDRESS INCLUDING ZIP CODE:	GEORGIA BAR #:	EMAIL:
PERSONAL REPRESENTATIVE (PARALEGALS MAY ACT IN THIS CAPACITY):	TEL NO:	FAX NO:
CURRENT ADDRESS INCLUDING ZIP CODE:	RELATIONSHIP TO CLAIMANT:	EMAIL:

LOCAL DFCS OFFICE

NAME OF OFFICE:	TEL NO: EMAIL:	FAX NO: EMAIL:
CURRENT ADDRESS INCLUDING ZIP CODE:	CASEWORKER'S NAME:	CASEWORKER'S DIRECT TELEPHONE NUMBER:
INDICATE DOCUMENTS ATTACHED:	SUPERVISOR'S NAME:	SUPERVISOR'S DIRECT TELEPHONE NUMBER: