

1. Check the application type if its EMA, if not proceed to step 3.
2. Check classic scorecard or evidence if there's a 526 available. Note the live tracker if there's no 526.
3. Download all documents that are applicable for the application from PACE.
 - For all EMA/526 application type – All forms
 - For Non-EMA application type – 5459 and itemized bill
 - All application type – Personal and Financial (Scanned)

Form 216 Itemized Bill

DECLARACIÓN DE CIUDADANÍA/ESTADO MIGRATORIO
 Departamento de Servicios Humanos de Georgia
 Dirección de Servicios para la Familia y los Niños

Entiendo que la División de Servicios para la Familia y los Niños (DIFCS) del estado de Georgia puede requerir la verificación del Departamento de Seguridad Nacional (DHS) de la ciudadanía de mis hijos o su estado migratorio al solicitar los beneficios. La información que se reciba del DHS puede afectar la elegibilidad de mis hijos.

Por favor llene y firme UNA O AMBAS declaraciones en lo que respecta al estado de cada una de las personas que solicitan beneficios.

NIÑOS QUE SOLICITAN BENEFICIOS					
Nombre	Lugar de nacimiento (ciudad, estado, país)	Ciudadano de EE.UU.: páis de procedencia o legítimo comos inmigrante (integre lo que corresponda)	Fecha de naturalización o admisión a los EE.UU. (integre lo que corresponda)	Número de identificación de documento migratorio (si corresponde)	
		A-			

Yo _____ (NOMBRE EN LETRAS) debo de saber que la identidad del(s) niño(niños) identificados arriba y certificado bajo juramento que la información escrita y marcada arriba es verdadera.

FECHA: 08/16/2025

ADULTO(S) QUE SOLICITAN BENEFICIOS					
Nombre	Lugar de nacimiento (ciudad, estado, país)	Ciudadano de EE.UU.: páis de procedencia o legítimo comos inmigrante (integre lo que corresponda)	Fecha de naturalización o admisión a los EE.UU. (integre lo que corresponda)	Número de identificación de documento migratorio (si corresponde)	
Elvira Valencia Carrillo	Mexico			A-	

Yo _____ Elvira Valencia Carrillo _____ doy fe de la identidad del(s) adulto(s) identificados arriba y certificado bajo juramento que la información escrita y marcada arriba es verdadera.

FECHA: 08/16/2025

Firma: _____

Formulario 216 ENG-SP REV. 09/18

Emory HealthCare
 P.O. Box 406664
 Atlanta, GA 30384-6939

**EMORY
HEALTHCARE**

Itemized Bill

Patient: Simmons, Michael Jamar Admission Date: 08/18/25
 Hospital Account: 1045922057 Discharge Date: 08/27/25
 Primary Coverage: No coverage associated with this account Invoice Number:

If you have any questions regarding this information, please contact our customer service department at 404-778-7318 Monday - Friday, 8:30 a.m. to 4:00 p.m.

Total Charges 102,996.51

Date	Code	Description	CPT / HCPCS	Rate	Cost
08/18/25	3018301502	[HC Laboratory (Llt) (Lltb) Emzyme + Lactate Dehydrogenase]	J7615	0070	155.00
08/18/25	3247104502	[HC Diagnostic Test Kit (Dtk) Troponin I]	J7615	0070	35.00
08/18/25	2980000001	[HC Diagnostic Test Kit (Dtk) Troponin I]	J7615	0070	21.00
08/18/25	3095802502	[HC Complete Chb & Auto Coagulation Panel]	J5025	0305	123.00
08/18/25	3068763700	[HC Complete Blood Count (CBC)]	J7657	0306	217.00
08/18/25	3018300600	[HC Urine Analysis (Ua)]	J7605	0301	263.00
08/18/25	3018300601	[HC Urine Analysis (Ua) Comprehensive]	J8053	0301	310.00
08/18/25	3018300602	[HC Urine Analysis (Ua) Comprehensive]	J8053	0300	78.00
08/18/25	3018300603	[HC Collection Venous Blood/Venipuncture]	J3645	0300	118.00
08/18/25	3018388001	[HC Peptide B-Peptide - B-Type Natriuretic Peptide (Bnp)]	J3880	0301	118.00
08/18/25	06096	[HC Caffeine Sodium Phosphate 250 Mg (0409-10)]	J0696	0250	12.15
08/18/25	J7030	[HC Sodium Chloride Piggyback 100 Ml Bag (0303-30)]	J7030	0258	35.00
08/18/25	7309300002	[HC Electrocardiogram Tracing - Ecg 12-Lead]	J3005	0730	235.00
08/18/25	3058001000	[HC Levothyroxine Time - Prothrombin Time Inherent 350 Mg Instawell Solution (0407-14)]	J6910	0305	78.00
08/18/25	Q9967	[HC Levothyroxine Time - Prothrombin Time Inherent 350 Mg Instawell Solution (0407-14)]	J9967	0255	456.20
08/18/25	3072175001	[HC Chest Angio, Chest, Combi, Ind Image - CT Chest Angio W and WG IV Contrast]	J1275	0352	2,228.00
08/18/25	3069704001	[HC Culture - Bacterial Blood]	J7040	0308	205.00
08/18/25	3069704002	[HC Culture - Fungal Blood]	J7040	0308	205.00
08/18/25	J0456	[HC Aztreonam per 500 Mg (05150-174-10)]	J0456	0259	38.50
08/18/25	J7050	[HC Sodium Chloride 0.9% (03384-049-02)]	J7050	0250	35.00
08/18/25	4609470001	[HC Pulse Oximetry - Noninvasive, Oxygen Saturation Single Determination]	J4763	0400	108.00
08/18/25	410946401	[HC RI Patient Demo/Educ]	J4664	0410	360.00
08/18/25	4109464010	[HC RI Patient Demo/Educ]	J46640	0410	268.00
08/18/25	270000047	[HC Oxygen - O2 Admin/Daily]	J0270	1	181.00

Form 526

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Michael J Simmons
 Name of Individual/Consumer/Patient/Applicant
 08/07/1980
 Date of Birth
 IF AVAILABLE:
 ID Number Used by Requesting Agency ID Number Used by Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize: Change Healthcare (Part of Optum)
 (Name of Person or Agency Requesting Information)
 PO Box 740001, Atlanta, GA 30374
 (Address)

to obtain from: Fulton County DIFCS
 (Name of Person or Agency Releasing Information)

the following type(s) of information from my records (and any specific section thereof):
 All information that DIFCS has in my file in reference to my application, including personal identifications, notices and certifications.

for the purpose of: applying for health maintenance and/or the provision of treatment services.

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)
 one (1) year.
 the period necessary to complete all transactions on matters related to services provided to me.
 I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

9-2-25
 (Date) (Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) (Title or relationship to Individual) (Signature of Person or other Legally Authorized Representative, where applicable) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN
 (Date this authorization is revoked by Individual) (Signature of Individual or Legally authorized Representative)

(Form 5459 (Rev. 12/2021))

Provider's Name: Doraz
 3448 Buford Hwy
 Atlanta, GA 30329
 Patient's Address: Apt 7
 Patient's Telephone #: 678-702-9297
 Date of birth: 01/08/1982
 Navarrete-Nino
 DOB: 01/08/1982

PHYSICIAN'S STATEMENT
 FOR
 EMERGENCY MEDICAL ASSISTANCE

Individuals who do not meet Medicaid citizenship/alienage requirements may be eligible for Emergency Medical Assistance (EMA). EMA provides payment for the treatment of emergency when such care and services are necessary for the treatment of an emergency medical condition of the alien, provided such care and services are not related to either an organ transplant procedure or routine prenatal or postpartum care. An emergency is defined as:

Acute symptoms of sufficient severity (including severe pain) that in the absence of immediate medical attention could reasonably be expected to:

- Place the patient's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any body system or organ.

The individual will have to be noted as eligible for Emergency Medical Assistance under one of the Department's existing categories. Major categories include:

- Aged, blind, disabled;
- Pregnant women;
- Children under 19 years of age; or
- Parents in families with very low income.

This form should be completed and signed by the provider after the Emergency has occurred. Forms containing future dates of service are invalid.

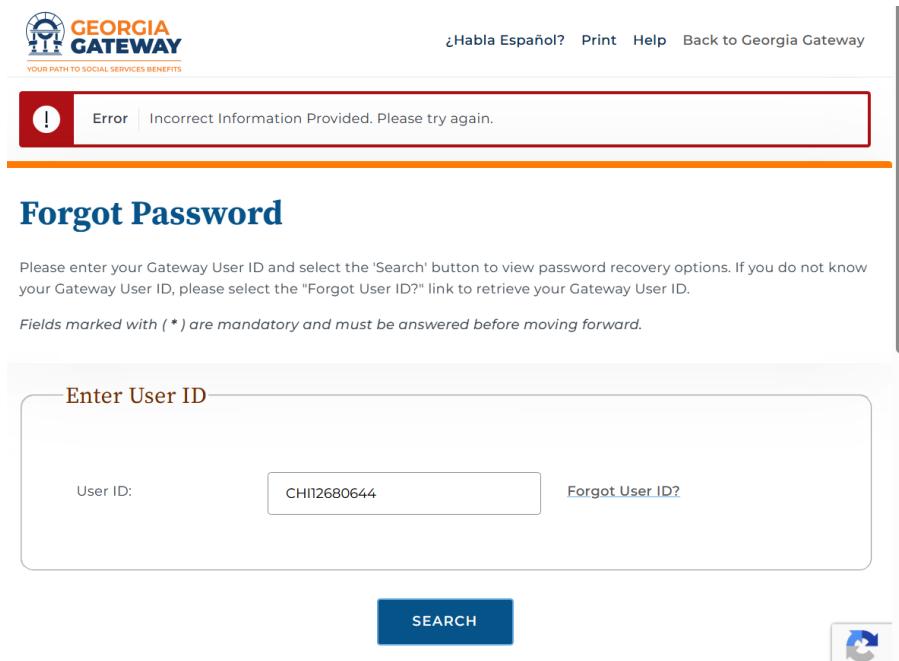
I provided EMERGENCY medical services on (Date of onset) through (Date) for the individual listed above.
 (Not to exceed 30 days from condition onset date)

(Provider's Name) (Provider or Authorized Designee's Signature)

(Provider's Address) (Date)

4. Check if there's login to Gateway.

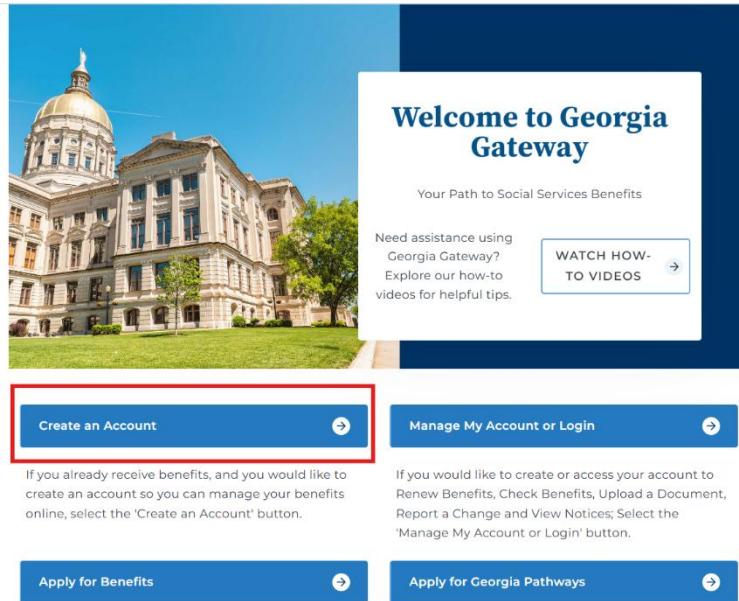
- If there are no errors encountered, proceed to step 5.
- If user ID is incorrect or password expired, click on forgot password. Put the default username then search for the account and put the default security answer to the questions. If there's no account found, proceed to 4C.



The screenshot shows the Georgia Gateway website's "Forgot Password" page. At the top, there is a logo for "GEORGIA GATEWAY" with the tagline "YOUR PATH TO SOCIAL SERVICES BENEFITS". To the right, there are links for "Habla Español?", "Print", "Help", and "Back to Georgia Gateway". A red error message box contains the text "Error | Incorrect Information Provided. Please try again." Below this, the main title "Forgot Password" is displayed in blue. A message instructs users to enter their Gateway User ID and select the "Search" button to view password recovery options. It also provides a link to "Forgot User ID?". The "Enter User ID" field contains the value "CHI12680644". To the right of the input field is a "Forgot User ID?" link. A "SEARCH" button is located below the input field. On the far right, there is a "Privacy - Terms" link with a dropdown arrow. The bottom half of the page shows three security questions and their answers:

* Security Question 1:	What is the name of your pet?
* Answer:	Optum
* Security Question 2:	What is your favorite food?
* Answer:	Financial
* Security Question 3:	What is your favorite song?
* Answer:	Services

c. If there's no account found, then follow the steps on the pdf.



Step 1: Your Name and Contact Method

Fill in your name below:

* First Name:

* Last Name:

By entering your Email Address, you are confirming it is okay for Georgia Gateway to send emails to you regarding your Georgia Gateway account. I acknowledge that there is no expectation of privacy in any Email and SMS communication that I send and receive.

Email Address: VERIFY Check here if you do not have an Email Address.

By entering your Mobile Phone Number, you are confirming it is okay for Georgia Gateway to send a One Time PIN (OTP) via text message to you regarding your Georgia Gateway account. Please know you will receive one message per request. Standard message and data rates may apply. Carriers are not liable for delayed or undelivered messages. I acknowledge that there is no expectation of privacy in any Email and SMS communication that I send and receive.

Mobile Phone Number: VERIFY Check here if you do not have a Mobile Phone Number.

Note: If you do not provide your Email Address or Mobile Phone Number, you will need to either answer security questions or call Customer Support Center 1-877-423-4746 to retrieve your Gateway User ID or reset your password.

Step 2: User ID and Password

To log in to your account, you will need to create a User ID and password. You will need these to log in on the next page. It's a good idea to write these down and keep them in a safe place.

User ID Requirements

* User ID:

- Must be 6-15 letters or numbers.
- Cannot contain special characters.

Password Requirements

* Password: ?

* Re-type your Password: ?

Are you an Authorized Representative? Yes No

Step 3: Security Questions

We're also asking "security questions" that you can use if you ever need to reset your password. Select the box below to choose questions that only you know the answer to. Then fill in your answer. It's a good idea to remember your information, since you will need to type it in exactly the same way if you lose your password.

* Security Question 1:	<input type="text" value="What is the name of your pet?"/>
* Answer:	Optum 
* Security Question 2:	<input type="text" value="What is your favorite food?"/>
* Answer:	Financial 
* Security Question 3:	<input type="text" value="What is your favorite song?"/>
* Answer:	Services 

Security Answer Requirements

- Must be a minimum of 3 characters
- Cannot contain hints or passwords from the selected security question
- Cannot contain personal information (e.g. First Name, Last Name, or Username)
- Cannot contain common answers (e.g. password, 12345678, Administrator)

Step 4: User Acceptance Agreement

- * As the last step in creating your account, check the box to let us know that you have read and agreed to the State's User Acceptance Agreement. [Select](#) to read the agreement, which tells you more about how we will keep your personal information private and secure. I acknowledge that there is no expectation of privacy in any Email and SMS communication that I send and receive.

[CREATE ACCOUNT](#)

5. Check Gateway if there's a pending application.

a. If there's no application available:

My Applications

Select link if you need to make a [PeachCare for Kids® Insurance payment.](#)



Already receive TANF, Food Stamps, Medical Assistance, CAPS or WIC benefits. Choose this button to link this Gateway account to your case so that you can:

- Add new benefits to your case
- Report Changes
- Upload documents
- Check your benefits
- Renew your Benefits
- View Notices
- Complete Periodic Report



[Apply for Benefits](#) 

Status Of Application

Currently, you have no applications.

Completing This Application

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Relationship to The Applicant

* Tell us your relationship to the Applicant. If you plan to apply for Child Care, you must choose Self or Legal Guardian. Select the 'Help' button for more information.

- Self
- Friend
- Family Member
- Staff Person or Agency Volunteer
- Authorized Representative
- Legal Guardian
- Power of Attorney
- Long Term Care or EDWP/CCSP Representative

Program Selection



- Medical Assistance (MA) including Pathways
- Child Care and Parent Services (CAPS)
- Food Stamps (SNAP)
- Temporary Assistance For Needy Families (TANF)
- Women, Infants and Children (WIC)

- * You may be asked to provide additional proof to determine eligibility.
- * You may file a "short application" for Food Stamps (SNAP), Medical Assistance or TANF with just your name, address, and signature or at any point in the application by selecting "Finish & Submit". We encourage you to answer as many questions as you can and sign your application today. This will allow us to help you more quickly. Select the 'Next!' button to continue.
- * You may submit an application for Food Stamps, Health Coverage for Children and Families and TANF with just your name, address and signature. If you want to apply for other programs you will need to start a new application for those programs.
- * For Food Stamps (SNAP), you will get an answer about your application within 30 days of your filing date. Your filing date is the day you sign and submit your application using this website OR if you submit your application after 5:00 p.m. or on a weekend or holiday, your filing date is the next business day.
- * You may be eligible for EXPEDITED Food Stamps (SNAP) if:
 - Your household has less than \$150 in income this month AND \$100 or less in cash and bank accounts
 - Your total monthly gross income and cash and bank accounts is LESS THAN your rent or mortgage and utility costs for this month

Contact Information

Let's get started on the application! First, please give us some basic information about you.

You may submit the application by selecting the "Finish & Submit" button now, or you may provide the information on this page if you choose to move forward.

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Information About You

The following content in the table allows user to enter Information About You.

* First Name	* Last Name	Preferred Language	If an interview is required will you need an interpreter?	Driver's License or State ID Number	Issuing State	Expiration Date
<input type="text"/>	<input type="text"/>	Select option to choose	<input checked="" type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="text"/>

Where You Live

* Street Number and Name, P.O. Box Number:

Apartment, Suite, Unit, Building, Plaza, etc.:

* City:

* State:

* Zip Code:

Country:

Do you receive your mail at a different address?

Are you homeless?

<input type="text"/>	<input type="text"/>
<input type="radio"/> Yes	<input checked="" type="radio"/> No
<input type="radio"/> Yes	<input checked="" type="radio"/> No

Add Authorized Representative

An Authorized Representative is a person or agency that has been granted permission by the applicant or **authorized family member or members** to assist with your application, renewal forms, report changes, and to receive copies of notices and other communications from the agency. An Authorized Representative should know about your financial and non-financial circumstances and, is designated by you to act on your behalf in matters related to your eligibility determination and continuing benefits. Please select "Page Help" to read details about Authorized Representatives.

For CAPS purposes only, an Authorized Representative can assist with completing the application and submitting verification documents. The parent is required to participate in the eligibility determination process.

Would you like to add an Authorized Representative at this time?

Yes
 No

PREVIOUS

SAVE AND EXIT

NEXT

Address Validation

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Confirm Your Address

* We have validated the addresses you have provided with the United States Post Office. Having an invalid address can delay receiving benefits and mail from us. Please select the address you would like us to use.

Home Address : We found other addresses similar to the address you entered.

Use this Home Address I entered

Patients address on PACE

Use this Standard Home Address

220 Bill Kennedy Way SE Apt 26, Fulton, Atlanta, Georgia, 30316-7217

PREVIOUS

SAVE AND EXIT

NEXT

Check here if this is a mobile number

VERIFY

Add Authorized Representative

An Authorized Representative is a person or agency that has been granted permission by the applicant or **authorized family member or members** to assist with your application, renewal forms, report changes, and to receive copies of notices and other communications from the agency. An Authorized Representative should know about your financial and non-financial circumstances and, is designated by you to act on your behalf in matters related to your eligibility determination and continuing benefits.

For CAPS purposes only, an Authorized Representative can assist with completing the application and submitting verification documents. The parent is required to participate in the eligibility determination process.

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Program Selection

* Please select the program or programs applicable for the Authorized Representative.

Select All Programs

Medical Assistance (MA)

- Child Care and Parent Services (CAPS)
- Food Stamps (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Women, Infants and Children (WIC)

Personal Information

Please enter personal information for the Authorized Representative.

* Are you the Authorized Representative?

Yes
 No

* First Name:

KIM

* Last Name:

HURT

Organization Name (If applicable):

Organization ID (If applicable):

* Relationship to Applicant:

Other Unrelated Adult

Residency Information

Please enter residency information for the Authorized Representative.

Are you homeless?

Yes
 No

* Street Number and Name, P.O. Box Number:

PO Box 00000000

Apartment, Suite, Unit, Building, Floor, etc.

* City:

Atlanta

* State:

Georgia

* Zip Code:

30350 - 036

Preferred Language and Interpreter

Please enter preferred language and interpreter information for the Authorized Representative.

Would you like to provide us information about your Authorized Representative's preferred language or need for an interpreter?

- Yes
 No

What is the Authorized Representative's preferred Language?

Select option to choose 

If an interview is required, will the Authorized Representative need an interpreter?

- Yes
 No

Would you like to add another Authorized Representative?

- Yes
 No

[PREVIOUS](#)

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[NEXT](#)

Address Validation

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Confirm Your Address

* We have validated the addresses you have provided with the United States Post Office. Having an invalid address can delay receiving benefits and mail from us. Please select the address you would like us to use.

Home Address : We found other addresses similar to the address you entered.

Use this Home Address I entered



Patients address on PACE

Use this Standard Home Address



220 Bill Kennedy Way SE Apt 26, Fulton, Atlanta, Georgia, 30316-7217

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[SAVE AND EXIT](#)

[NEXT](#)

Check here if this is a mobile number

[VERIFY](#)

Review Your Updates in Authorized Representative Summary

Review Your Answers: Authorized Representative

The following content in the table allows the user to review and change answers for the Authorized Representative.

Who?	Change	Remove
KIM HURT (Other Unrelated Adult)		

Add an Authorized Representative

To add an Authorized Representative, select the 'Add' button.

ADD

PREVIOUS

SAVE AND EXIT

NEXT

People In Your Home

Enter information for the first person and then use the 'Add Person' button to add more people to your application. Use the "X" icon next to each individual if you would like to remove an individual or a line you may have added by accident.

The questions about your race and ethnicity are being asked for statistical purposes to ensure we are giving fair and equal treatment to everyone. Your answers are voluntary and will have no effect on your eligibility or services for any program.

You may submit the application by selecting the 'Finish & Submit' button now, or you may provide the information on this page if you choose to move forward.

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

About the people in your Home

The following content in the table allows user to enter details About the people in your Home.

* First Name	* Last Name	Maiden Name	* Date of Birth Ex: mm/dd/yyyy	* Sex	Sex Assigned at Birth	If not listed, please specify	Ethnicity	Citizenship Information	SSN	Remove
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

ADD PERSON

PREVIOUS

SAVE AND EXIT

NEXT

Social Security Number, Citizenship & Immigration Status

If you are applying for WIC only, you do not have to tell us about your citizenship or immigration status or provide us your Social Security Number.
The following federal laws and regulations:

- The Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7 C.F.R. § 273.2, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, authorize DFCS to request you and your household members social security number(s).
 - Anyone who is living in your household and is not applying for benefits may be treated as a non-applicant.
 - Non-applicants do not have to give us information about their social security number, citizenship, or immigration status and are not eligible for benefits.
 - Other household members may still be able to receive benefits, if they are otherwise eligible.
 - If you want us to decide whether any household members are eligible for benefits, you will still need to tell us about their citizenship or immigration status and give us their social security number (SSN).
- You will still need to tell us about their income and resources to determine the eligibility and benefit level of the household.
 - We will not report any non-applicant household members to the United States Citizenship and Immigration Services (USCIS) Systematic Alien Verification for Entitlements (SAVE) system if they do not give us their citizenship or immigration status.
 - However, if immigration status information has been submitted on your application, this information may be subject to verification through the SAVE system and may affect the household's eligibility and benefit level.
 - We will match your information with other Federal, state, and local agencies to verify your income and eligibility.
 - This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a Food Stamp claim, the information on this application, including SSN, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim.
 - We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status.

PREVIOUS

SAVE AND EXIT

NEXT

People In Your Home - Race Information

Please report Race information for each person in the household. Please note this information will not impact your eligibility determination. You may choose more than one race or all that apply. You may submit the application by selecting the 'Finish & Submit' button now, or you may provide the information on this page if you choose to move forward.

Miracle (21 Years)

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Persian |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> White |
| <input type="checkbox"/> East Asian | <input type="checkbox"/> Asian | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Other |

PREVIOUS

SAVE AND EXIT

NEXT

More About the People in Your Home

You may submit the application by selecting the 'Finish & Submit' button now, or you may provide the information on this page if you choose to move forward.

Please provide information for each household member.

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Miscellaneous Information

The following content in the table allows user to enter Miscellaneous Information for each household member.

* First Name	* Does this person have a disability?	Is this person a veteran or in active duty military?	Is this person pregnant or breastfeeding or postpartum?	* Does this person plan to file taxes?	* Is this person claimed as a tax dependent by someone outside the home?	* What is this person's living arrangement?	If not in the home, when did this living arrangement begin?
Yes	No	No	No	No	No	In This Home	mm/dd/yyyy

Income Verification via Truv

Truv is a service that can access real-time employment verification from its portal of employer and payroll companies.

Follow the below steps to complete the Truv verification:

① Start the verification.

If you wish to report income from a job for any of the people listed below and electronically verify it via Truv, select "Yes" in the dropdown and then the 'Verify Instantly' button provided next to their name. This will open the Truv widget where you may search for your employer or payroll provider. The Truv widget will take you to your employer or payroll portal.

② Sign into your employer or payroll portal.

Benefits of using Truv



Takes a few minutes.
Most U.S. employers are supported.



Secure and paperless.
No one can see your credentials.



Trusted by millions.
Industry-standard security and encryption.

The following content in the table allows the user to verify income via Truv.

First Name	* Does this person wish to report income from a job?	Verify Income
	<input style="border: 1px solid #ccc; padding: 2px 10px; width: 100%;" type="button" value="No"/>	<input style="background-color: #0070C0; color: white; border: none; padding: 2px 10px; width: 100%;" type="button" value="VERIFY INSTANTLY"/>

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Other Adults (18+) Seeking Benefits

The following content in the table lists the citizenship and immigration status of the adults in the household.

Name	U.S.Citizen	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S.	* Do you attest to individual's citizenship or immigration status?
I				<input type="radio"/> Yes <input checked="" type="radio"/> No

Electronic Signature

I understand that an electronic signature has legal effect and can be enforced in the same way as a written signature.

* I attest to the citizenship or immigration status of the children under 18 above and the adults for whom I have selected yes above and certify under penalty of perjury that the information above is true.

* First Name:	Middle Initial:	* Last Name:	Suffix:
<input style="width: 100%;" type="text" value="Miracle"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text" value="Johnson"/>	<input style="width: 100%;" type="text" value="Select option to choose"/>

[PREVIOUS](#) [SAVE AND EXIT](#) [NEXT](#)

More About Miracle's Disability Status

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

You've told us that Miracle is disabled or blind. Please tell us a little bit more about this.

Miracle's Disability or Blindness

* What is Miracle's Disability Status?

- Blind
- Mental
- Physical

* Nature of Disability:

* Does Miracle have another disability to report?

- Yes
- No

[PREVIOUS](#)

[SAVE AND EXIT](#)

[NEXT](#)

Planning for Healthy Babies®

Next, we need to know if anyone in the applicant group is eligible for Planning for Healthy Babies® (P4HB).

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Planning for Healthy Babies®

* Is any one in the applicant group applying for Planning for Healthy Babies®? Otherwise, select "No one".

Planning for Healthy Babies® (P4HB) provides no-cost family planning services to eligible women in Georgia. P4HB covers annual physical exams including pap smt or rescreening for a sexually transmitted infection (STI); and more. For more information visit <https://medicaid.georgia.gov/all-programs/planning-healthy-babies>.

No One

Miracle (21 yrs)

PREVIOUS

SAVE AND EXIT

NEXT

The following questions regarding individual information are mandatory. You will have an option to select an answer of "No One" for unanswered questions at the end of this section.

Questions	Miracle Smith	No One	Someone out of household
* Has this person aged out of foster care at age 18 or older?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Is anyone currently receiving, or has recently received, Food Stamps (SNAP), Temporary Assistance for Needy Families (TANF) or Medicaid in another state?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Is this person receiving Medicare Part A or Part B or is this person entitled to Part A or Part B? By entitled, we mean that you are able to get the benefit, even if you are not actually getting it.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Is anyone currently enrolled in, or have access to, Health Coverage? If yes, please select the policy holder(s).	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
* Has this person received Supplemental Security Income (SSI), but is no longer getting this benefit?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Is this person receiving Home and Community Based (waiver) Services (CCSP, ICWP, NOW or COMP)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Is anyone currently in or, within the last 3 months, has been in the hospital for at least 30 days in a row?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Has this person lost health insurance coverage (not Medicaid) in the past two months?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Is this person currently receiving Hospice care?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Is this person currently residing in a nursing home?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Has this person received health services from Indian Health Services, a tribal health program, an urban Indian health program, or through a referral from one of those programs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
* Is this person eligible to receive health services from the Indian Health Services, a tribal health program, an urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

Select this box to choose "No One" for all unanswered questions in this section

Confirmation

* You indicated that no one in your household has any of the circumstances listed above. Is the information entered on this page accurate in describing your household? Providing as much information as possible while applying for benefits will help the State process your application in a more timely manner.

Yes
 No

PREVIOUS

SAVE AND EXIT

NEXT

Resources

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Tell us about your resources

* Does anyone in your home have any resource or assets including cash, checking accounts, savings accounts, vehicles, burial items, life insurance, or real estate?

Yes
 No

[PREVIOUS](#)

[SAVE AND EXIT](#)

[NEXT](#)

Income

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Tell us about your Employment Income

* Does anyone in your home have any income from a job?

Yes
 No

Note: Please choose "Yes" if you have received any employment income this month even if that employment income will not continue in the future. If you have linked your employer portal via Truv, please choose "Yes".

Tell us about Other Income

* Does anyone in your home have any income including self employment income, or income from any other source (including money from family or friends to help with your expenses)?

Yes
 No

Note: Please choose "Yes" if you have received any income this month even if that income will not continue in the future.

[PREVIOUS](#)

[SAVE AND EXIT](#)

[NEXT](#)

Bills

Please list here the amount each person pays monthly for medical bills, child support or adult or child care.

Other Bills

The following content in the table allows the user to report non-housing bills.

First Name	Type of Bill	Total Amount	Amount You Pay	Amount Paid by Others	If paid by others, provide name	If paid by others, provide contact number	Remove Bill
------------	--------------	--------------	----------------	-----------------------	---------------------------------	---	-------------

ADD BILL

Unpaid Medical Bills

Select individuals that have unpaid medical bills from last 3 months.

- No One
 Miracle (21 yrs)

Income Tax Deductions

Do you have deductions expenses that can be deducted on an income tax return?

- No One
 Miracle (21 yrs)

Before Tax Deductions

Do you have before tax deductions (such as dental or vision insurance premiums)? Before deductions are deductions taken from your pay before the taxes are calculated and withheld.

- No One
 Miracle (21 yrs)

PREVIOUS

SAVE AND EXIT

NEXT

Georgia Pathways to Coverage™

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Learn More About Pathways

Georgia Pathways to Coverage™ is a new program to help low-income Georgians qualify for Medicaid who otherwise would not be eligible for traditional Medicaid. To be eligible for Pathways, you must be between the ages of 19-64 and participate in 80 hours of qualifying activities per month. Qualifying activity requirements will only apply to Pathways and not those who are enrolled in other Georgia Medicaid programs.

To be eligible for Pathways, you must:

- Be a Georgia resident.
- Be a U.S. citizen or legally residing non-citizen.
- Be between 19 and 64 years of age.
- Have a household income of up to 100% of the Federal Poverty Level (FPL). Please visit the [FPL Income Guidelines](#) for details.
- Participate in 80 hours of a qualifying activity or activities per month.
- Not qualify for any other type of Medicaid.
- Not be incarcerated.

At the time of your application for Pathways, you must demonstrate that currently, and in the month prior to your application, you are participating in 80 hours of a qualifying activity or combination of activities. Qualifying activities include:

- Full-time or part-time employment
- On-the-job training
- Job readiness assistance programs
- Community service
- Vocational Education Training
- Enrollment in the Vocational Rehabilitation program of the Georgia Vocational Rehabilitation Agency (GVRA)
- Higher education

Note: At application, you may need to provide documentation to verify your qualifying activities.

- Once you have met the qualifying activities requirement and have been approved for Pathways, to keep your Pathways coverage, you must continue to meet the 80-hour qualifying activity requirement each month.
- Applicants or members who report a minimum of 80 hours of part-time or full-time employment per month for six consecutive months prior to application, or 80 hours of qualifying activities for six consecutive months once enrolled in Pathways will not need to report qualifying activities again until annual renewal.

* Now that you have reviewed Pathways Program requirements, please select any household member(s) that are still interested in the Pathways Program. If a household member is not selected, they will not be evaluated for the Pathways Program.

- No One
 Miracle (21 yrs)

To be eligible for Georgia Pathways to Coverage™, you must perform one or more qualifying activities for 80 hours each month. You've indicated that you do not believe you are meeting this requirement. For more information on how to find qualifying activities, and resources that can help you meet this requirement, visit <https://pathways.georgia.gov/qualifying-activities/qualifying-activities-resources>

PREVIOUS

SAVE AND EXIT

NEXT

Signing Your Application

You're just a few minutes away from submitting your application. To do so, you'll need to:

- Read the Rights and Responsibilities we've listed below.
- Check the signature box and type your name below to sign your application.

Fields marked with (*) are mandatory, and must be filled out before continuing with your application.

Responsibilities, Rights and Penalties



Consent to Exchange Information



ADA 504 Statement



Non-Discrimination



Citizenship Information



Please certify the following:

- If I am applying for someone else I certify to the best of my knowledge and belief that the person(s) for whom I am applying for health coverage is or are United States citizen(s), national(s) or qualified immigrant(s). I further certify that all of the information provided on this application is true and correct to the best of my knowledge.

Renewal of Coverage in Future Years



To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

* Yes, renew my eligibility automatically for the next

- 5 years (the maximum number of years allowed), or for a shorter number of years:
 4 years
 3 years
 2 years
 1 year

Don't use information from tax returns to renew my coverage.

Voter Registration



If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. For help in filling out the voter registration application form, you may call the Georgia Secretary of State's office at 404-656-2871.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at: 2 Martin Luther King Jr. Drive, Suite 802, West Tower, Atlanta, GA 30334 or by calling 404-656-2871.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

TO SUBMIT YOUR APPLICATION FOR BENEFITS, SELECT ONE OF THE THREE 'SUBMIT' BUTTONS BELOW. NONE OF THE THREE 'SUBMIT' BUTTONS BELOW WILL REGISTER YOU TO VOTE. IF YOU WANT TO APPLY TO REGISTER TO VOTE, ADDITIONAL STEPS ARE NEEDED TO COMPLETE THE VOTER REGISTRATION PROCESS. VOTER REGISTRATION INFORMATION IS PROVIDED BELOW.

Electronic Signature

I have agreed to submit this application for myself or my family. By signing this application electronically, I certify under penalty of perjury and false swearing that my answers are true and accurate to the best of my knowledge, including information provided about the citizenship or immigration status for each household member applying for benefits. I also certify that:

I agree to submit this application by electronic means. By signing this application electronically, I understand that an electronic signature has the same legal effect and can be enforced in the same ways as a written signature.

I understand the questions and statements on this application.

I have read and understand my Rights & Responsibilities in the box above.

I understand the penalties for giving false information or breaking the rules.

I understand that the agency may contact other persons or organizations to obtain needed proof of my eligibility and level of benefit.

The Georgia Department of Human Services ("DHS") collects Personally Identifiable Information (PII), such as names, addresses, telephone numbers, email addresses, and dates of birth, etc., during your application for benefits. By submitting any personal information to us, you agree that we may collect, use, and disclose any such personal information in accordance with DHS policies, procedures, and as permitted or required by law or regulations.

I understand that failure to report or verify any listed expenses will be seen as a statement by me that I do not want to receive a deduction for the unreported or unverified expenses of my Medical Assistance or TANF benefits.

I understand I can be punished by law if I do not tell the complete truth.

By checking this box and typing my name below, I am electronically signing this application as an Authorized Representative.

* First Name: KIM

* Last Name: HURT

Suffix:
Select option to choose

By checking this box and typing my name below, I am electronically signing my application.

* First Name:

Middle Initial:

* Last Name:

Suffix:

KIM

HJRT

Select option to choose

TO SUBMIT YOUR APPLICATION FOR BENEFITS, SELECT ONE OF THE THREE 'SUBMIT' BUTTONS BELOW. NONE OF THE THREE 'SUBMIT' BUTTONS BELOW WILL REGISTER YOU TO VOTE. IF YOU WANT TO APPLY TO REGISTER TO VOTE, ADDITIONAL STEPS ARE NEEDED TO COMPLETE THE VOTER REGISTRATION PROCESS.

PREVIOUS

SAVE AND EXIT

SUBMIT
YES, I WANT TO APPLY TO REGISTER
TO VOTE WHERE I LIVE. My Voter
registration information will be
provided on the next page

SUBMIT
NO, I DO NOT WANT TO APPLY
TO REGISTER TO VOTE WHERE I
LIVE NOW

SUBMIT
I DO NOT WANT TO ANSWER THE
VOTER REGISTRATION QUESTION.
(Voter registration information will be
provided on the next page)

b. If there's an application available:

6. Scroll down to Status of Application and click 'Select here to continue application'.

*if the page that loads does not show 'Status of Application' at the bottom, go to **Quick tips**

#6

Status Of Application

To view a PDF copy of your submitted applications select the Details icon.
The following content in the table lists the Status Of Application.

Submitted By: Eleanor Cutler

Application Number: [Select to continue application](#)

Status: In Progress

Date of Last Access or Date Submitted: 01/15/2026

Program Applied For: MA (Medical Assistance)

Details:

Scheduled Appointments:

Would you like to upload documents?: N/A



Status Tracker:



Submission

Your application is pending submission.

7. The next page will show “Signing Your Application” at the top – scroll to the bottom of the page

Get Started Resources Income Bills Finish & Submit

Finish Finish & Submit

Signing Your Application

You're just a few minutes away from submitting your application. To do so, you'll need to:

- Read the Rights and Responsibilities we've listed below.
- Check the signature box and type your name below to sign your application.

Fields marked with (*) are mandatory, and must be filled out.

8. At the bottom of the page, click the ‘Submit’ button to the far right

I understand I can be punished by law if I do not tell the complete truth.
 By checking this box and typing my name below, I am electronically signing this application as an Authorized Representative.

* First Name: * Last Name: Suffix:

* By checking this box and typing my name below, I am electronically signing my application.
* First Name: Middle Initial: * Last Name: Suffix:

TO SUBMIT YOUR APPLICATION FOR BENEFITS, SELECT ONE OF THE THREE ‘SUBMIT’ BUTTONS BELOW. NONE OF THE THREE ‘SUBMIT’ BUTTONS BELOW WILL REGISTER YOU TO VOTE. IF YOU WANT TO APPLY TO REGISTER TO VOTE, ADDITIONAL STEPS ARE NEEDED TO COMPLETE THE VOTER REGISTRATION PROCESS.

PREVIOUS SAVE AND EXIT

SUBMIT
YES, I WANT TO REGISTER
TO VOTE WHERE I LIVE NOW
(Voter registration information will be
provided on the next page)

SUBMIT
NO, I DO NOT WANT TO APPROVE
TO REGISTER TO VOTE WHERE
I LIVE NOW

SUBMIT
I DO NOT ANSWER THE
VOTER REGISTRATION QUESTION
(Voter registration information will be
provided on the next page)

9. Click ‘Next’ at the bottom of the next page. It will reload, and you will click ‘Next’ again.

Application Wrap Up

You are not required to upload any document to submit an application. However, verification may be needed to determine program eligibility. You may upload any verification that may help with determining eligibility. Once the application is received, a verification checklist will be sent requesting the verification that is required for each program to determine eligibility.

If you have previously provided the verification, there is no need to re-upload the documents.

Head of Household Identity Verification

You will now have the opportunity to upload documents for the Head of Household to provide proof of identity. Select the document type and then select the ‘Choose File’ button to upload the file to your application. If you wish to continue without uploading the document select ‘Next’.

Name	Validation	Document Type	File Name	Remove
Kimberly Carter	Identity	Select to choose	<input type="button" value="Choose file"/>	

Head of Household Residency Verification

You will now have the opportunity to upload documents for the Head of Household to provide proof of Residency. Select the document type and then select the ‘Choose File’ button to upload the file to your application. If you wish to continue without uploading the document select ‘Next’.

Name	Validation	Document Type	File Name	Remove
Kimberly Carter	Residency	Select to choose	<input type="button" value="Choose file"/>	

Citizenship Verification

You will now have the opportunity to upload documents for yourself or members of your household to provide proof of Citizenship. Select the document type and then select the ‘Choose File’ button to upload the file to your application. If you wish to continue without uploading the document select ‘Next’.

Name	Validation	Document Type	File Name	Remove
Kimberly Carter	Citizenship	Select to choose	<input type="button" value="Choose file"/>	

Income Verification

You will now have the opportunity to upload documents for yourself or members of your household to provide proof of income. Select the document type and then select the ‘Choose File’ button to upload the file to your application. If you wish to continue without uploading the document select ‘Next’.

Name	Employer	Document Type	Number of Paystubs	File Name	Remove
Kimberly Carter	Previous	Select to choose		<input type="button" value="Choose file"/>	

NEXT

10. Next, reference the application type in PACE. If the application type includes 'EMA', go to step 11. If not, follow steps 16-19.

Applications and Visits Recap				
Type	Status - Reason	Work	Applied for Dates	Next Process
RSM-EMA-05/15/24 (I)	Taken - Not Sent	Work	05/10/24 - 05/25/24	
Visit: 05/14/24 (IP)	Northside-OB	2421100011	\$0.00	Pending Approval
	> Approved - Eligibility			

11. Click Print Copy of Application.

Hello, Eleanor. You are logged in.

Congratulations! Your application has been successfully submitted.

Your tracking number is T47587539 for Medicaid
Please print or save this page for your records.

We encourage you to upload documents to support your application.

You are encouraged to upload documents to prove your identity, income and expenses.

[UPLOAD DOCUMENTS](#)

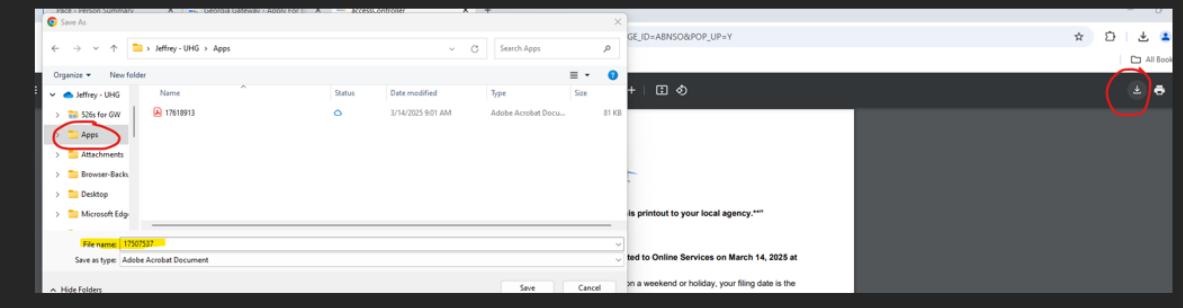
If you would like to print or save a copy of your application for your files, please select the 'Print Copy of Application' button below. If you decide to print or save, please keep in mind that your application has your private, personal information in it. A copy of your application will be saved and can be viewed by logging into your account.

Advisory- Please read:

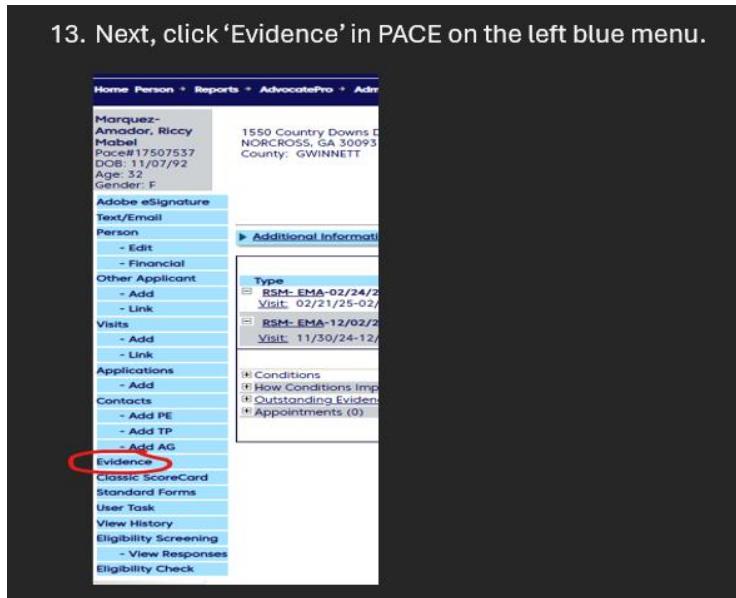
The information you just created is secure, but if you are using a computer in a Library, Community Center or other public place, please take these additional steps: If you print anything, remember to get the printed copies of your summary. If the printer jams or your summary fails to print, contact someone at the location for help. After you have completed entering your information, shut down the Internet program and if possible ask the staff to restart the computer.

[PRINT COPY OF APPLICATION](#)

12. Once the application opens, click the down arrow icon. A window will pop up. You will select the 'Apps' folder. Name the file with the PACE number. And Save. Then close the tab with the application.



13. Next, click 'Evidence' in PACE on the left blue menu.



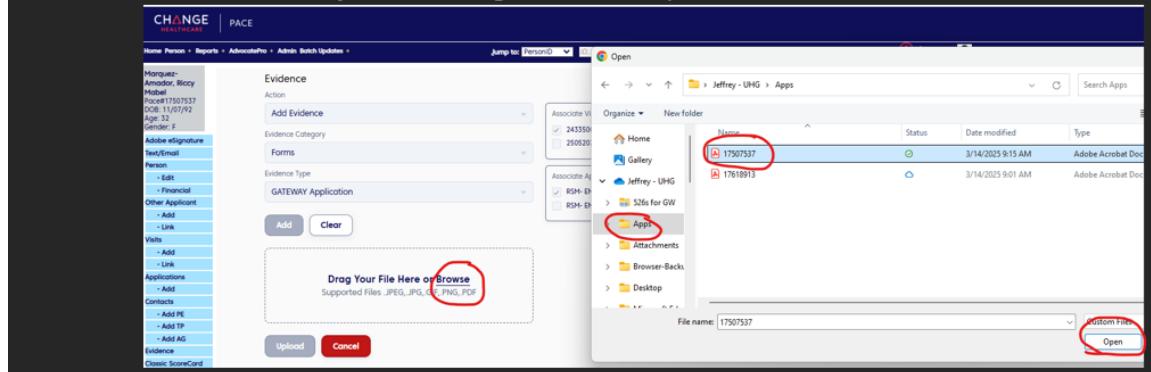
14. Update the 'Action' field to 'Add Evidence'. Update 'Evidence Category' to 'Forms'. In the Evidence Type search 'gateway' and select 'GATEWAY APPLICATION'.

The screenshot shows the 'Evidence' creation form in PACE. The left sidebar has the 'Evidence' option selected. The main form has the following fields: Action (set to 'Add Evidence'), Evidence Category (set to 'Forms'), Evidence Type (set to 'gateway', with 'GA GATEWAY Authorization Form' listed under it), and two additional fields: 'GATEWAY APPLICATION' (which is highlighted in yellow) and 'GATEWAY CONFIRMATION' (which is grayed out). Below these are 'GATEWAY EVIDENCE' and 'GATEWAY TRACKING NUMBER' fields.

15. Select the account and application you are working. You can identify this based on the date of the application and account.

The screenshot shows the 'Evidence' section of the software. On the left, there's a sidebar with various links like 'Adobe eSignature', 'Text/Email', 'Person', 'Other Applicant', 'Visits', 'Applications', 'Contacts', and 'Evidence'. The 'Evidence' link is highlighted. In the main area, there are dropdown menus for 'Action' (set to 'Add Evidence'), 'Evidence Category' (set to 'Forms'), and 'Evidence Type' (set to 'GATEWAY Application'). To the right, there are two sections: 'Associate Visit(s)' and 'Associate Application(s)'. Both sections have checkboxes for specific entries, with some checked. At the bottom, there are 'Add' and 'Clear' buttons, with the 'Add' button circled in red.

16. Click 'Browse'. A window will pop up. From the 'Apps' folder you will select the file with the PACE number you are working. Then, click 'Open'



17. Next, click 'Upload'. The application is now saved to the scorecard.

The screenshot shows the 'Evidence' section again. The file '17507537.pdf' is now listed in the evidence area. At the bottom, there are 'Upload' and 'Cancel' buttons, with the 'Upload' button circled in red.

19. Go back to Gateway and click 'Upload Documents'

Hello, Eleanor. You are logged in.

Congratulations! Your application has been successfully submitted.

Your tracking number is T47587539 for Medicaid

[Please print or save this page for your records.](#)

We encourage you to upload documents to support your application.

You are encouraged to upload documents to prove your identity, income and expenses.

[UPLOAD DOCUMENTS](#)

If you would like to print or save a copy of your application for your files, please select the 'Print Copy of Application' button below. If you decide to print or save, please keep in mind that your application has your private, personal information in it. A copy of your application will be saved and can be viewed by logging into your account.

Advisory- Please read:

The information you just created is secure, but if you are using a computer in a Library, Community Center or other public place, please take these additional steps: If you print anything, remember to get the printed copies of your summary. If the printer jams or your summary fails to print, contact someone at the location for help. After you have completed entering your information, shut down the Internet program and if possible ask the staff to restart the computer.

[PRINT COPY OF APPLICATION](#)

20. Select Income, Resources and Expenses for Step 1a and select Medical Bills/Documents for Step 1b.

Document Upload

* Step 1a: Please select the document category

Income, Resources and Expenses

* Step 1b: Please select the document type

Medical Bills/Documents

21. In the Step 2 section, select 'Application Selection', check the box for 'Medical Assistance', and in the drop down select the first name listed. Then, click 'Attach'

* Step 2: Next you will select what case(s) or application(s) this document is for.

Application Selection

Select:	<input checked="" type="checkbox"/>
Programs Applied For:	Medical Assistance (MA)
Application Number:	T47587539

* Step 3: Please tell us who this documentation is being uploaded for. Only upload this document one time.

Note: If you are uploading a household level document, this field will be disabled.

Select option to choose

* Step 4: Select Attach to browse your documents and select the one you would like to upload.

ATTACH

23. Once the page reloads, scroll to the bottom of the page to 'Documents Pending Submission'.

Documents Pending Submission

The following content in the table lists the Documents Pending Submission.

Date	File Name	Document Type	Client	Case or Application	Benefit or Program	Submission Status	Remove
01/16/2026	1052305434 17967482 Cutler, Eleanor 216.pdf	Medical Bills/Documents	Eleanor Cutler	T47587539	Medical Assistance (MA)	Upload Pending	
01/16/2026	1052305434 17967482 Cutler, Eleanor 526.pdf	Medical Bills/Documents	Eleanor Cutler	T47587539	Medical Assistance (MA)	Upload Pending	
01/16/2026	1052305434 17967482 Cutler, Eleanor 5459.pdf	Medical Bills/Documents	Eleanor Cutler	T47587539	Medical Assistance (MA)	Upload Pending	
01/16/2026	1052305434 17967482 Cutler, Eleanor itemized bill.pdf	Medical Bills/Documents	Eleanor Cutler	T47587539	Medical Assistance (MA)	Upload Pending	

SUBMIT

24. Go back to PACE, and click on the application name

Applications and Visits Recap				
Type	Status - Reason	Work	Applied for Dates	Next Process
RSM-EMA-05/15/24 (I) Visit: 05/14/24 (IP)	Taken - Not Sent Northside-OB	Work 2421100011	05/10/24 - 05/25/24 \$0.00	Pending Approval
			Approved - Eligibility	

25. Enter the information in the associated fields. Tracking Number is the 'Case/Application' number that begins with a T seen in the screen shot for step #15. Status should be changed to 'Application Submitted' from the drop down selections, and 'Sent to Agency Date' will be the date you are submitting the application in Gateway.

Ortega-Ochoa, Yaragza
Pace#9644949
DOB: 12/22/95
Age: 28
Gender: F

Adobe eSignature

Text/Email Person

- Edit
- Financial
- Add
- Link

Visits

- Add
- Link

Applications

- Add

Contacts

- Add PE
- Add TP
- Add AG

Evidence

Classic ScoreCard

Standard Forms

User Task

View History

Eligibility Screening

- View Responses

Eligibility Check

Edit Application for Yaragza Ortega-Ochoa

Applicant Address Info

1605 Calvin Davis Cir
LAWRENCEVILLE, GA 30043

Application Info

Case Number:

Tracking #: **T35013044**

Category: *

State: * Georgia

Type: * RSM

Level: * Initial

Status: * Application Submitted

Customer: NH-Northside Hospital-OB

Office: Atlanta

HCR: * Garcia, Dayma

CP: Choose...

RS: Authorization EMA

Months Applied For: 5/10/2024 to 5/25/2024

State Online Application Submitted:

State Online Application Initiated: 5/15/2024

Taken Date: * 5/15/2024

Fax Protected Date:

CHC Sent to POD Date:

CHC Received Date:

QA Start Date:

QA Complete Date:

Sent to Agency Date: **7/27/2024**

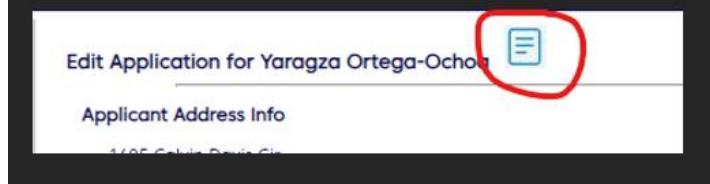
Agency Received Date:

[Enable All Levels](#)

No Existing Coverage [Click here to enter an additional coverage](#)

Save Cancel

26. Next, select the icon to add a Note



27. Using the information in GW under 'Documents Pending Submission' (seen in step 15), begin completing the note for PACE. Select 'Private', Role Type = HCR, Note Template type = Custom Notes. Then, use the format in the note below to standardize your notes, but Do Not save your note yet.

*If application is not EMA, your note will only be the first line of the note below, then go to step #22

Note Template

Role Type * HCR

Private High Importance Add to all active visits ⓘ

Note Template * Custom Notes

Note *

T36312917, GW app submitted 1.15.25
526 uploaded for account 2428803508
TX#

28. Go back to Gateway and click ‘Submit’ under the Documents Pending Submission section. Once the page re-loads, scroll to the bottom of the page.

Documents Pending Submission

The following content in the table lists the Documents Pending Submission.

Date	File Name	Document Type	Client	Case or Application	Benefit or Program	Submission Status	Remove
01/16/2026	1052305434 17967482 Cutler, Eleanor 216.pdf	Medical Bills/Documents	Eleanor Cutler	T47587539	Medical Assistance (MA)	Upload Pending	
01/16/2026	1052305434 17967482 Cutler, Eleanor 526.pdf	Medical Bills/Documents	Eleanor Cutler	T47587539	Medical Assistance (MA)	Upload Pending	
01/16/2026	1052305434 17967482 Cutler, Eleanor 5459.pdf	Medical Bills/Documents	Eleanor Cutler	T47587539	Medical Assistance (MA)	Upload Pending	
01/16/2026	1052305434 17967482 Cutler, Eleanor itemized bill.pdf	Medical Bills/Documents	Eleanor Cutler	T47587539	Medical Assistance (MA)	Upload Pending	

SUBMIT

29. At the bottom of the page under History of Documents Upload, you will see the Transaction Number for the document uploaded. Copy and paste that number into the PACE note. Next, copy the note entered and then click ‘Save’

History of Documents Uploaded

The following content in the table lists the History of Documents Uploaded.

Date	Document Type	Client	Case/Application	Benefit/Program	Submission Status	Transaction Number
08/27/2024	Medical Bills/Documents	Yaragua Ortega-Ochoa	T35013044	Medical Assistance (MA)	Submitted	IESUC013401403

Previous **Next**

Note Template

Role Type *
HCR

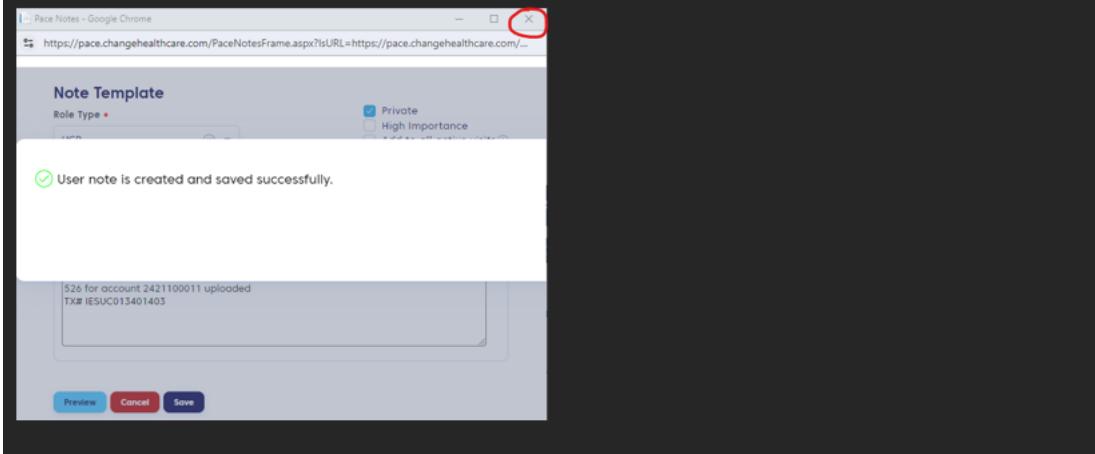
Note Template *
Custom Notes

Note *

T36312917, GW app submitted 1.15.25
526 uploaded for account 2428803508
TX# IESUC015008868

Save **Cancel** **Preview**

30. Once the User note is created and saved successfully, close out of the note window



31. Then, click Save in PACE on the Edit Application page

A screenshot of the "Edit Application for Yaragza Ortega-Ochoa" page in PACE. The left sidebar shows a navigation menu with various options like "Person", "Other Applicant", "Visits", etc. The main form contains fields for "Case Number" (T35013044), "Tracking #", "Category", "State", "Type", "Level", "Status", "Customer", "Office", "HCR", "CP", "RS", and "Authorization". There are dropdown menus for "Initial", "Fox Protected Date", "CHC Sent to POD Date", "CHC Received Date", "QA Start Date", "QA Complete Date", "Sent to Agency Date", and "Agency Received Date". Below these are date pickers for "Months Applied For" (5/10/2024 to 5/25/2024), "State Online Application Submitted", and "State Online Application Initiated" (5/15/2024). A "Save" button is highlighted with a red circle at the bottom center of the form. A note at the bottom says "Click here to enter an additional coverage".

32. On the next page, select Person from the left menu, then you will see the application status has been successfully updated to 'Pending-Application Submitted'

A screenshot of the "View Applications for Yaragza Ortega-Ochoa" page in PACE. The left sidebar shows a navigation menu with "Person" selected. The main content area shows two sections: "Hospital: NH-CIMA" with "Active" and "In-Active" status checkboxes, and "Hospital: NH-Northside Hospital-OB" with a table showing application details. The table has columns for Type, Taken, Level Status, Office, Submitted, Approval, Denial, CHC Received, Medicaid #, Resolution Specialist, and Notes. One row in the table is highlighted with yellow boxes around the "Status - Reason" and "Work" columns, both of which show "Pending - Application Submitted". Below the table is a section for "Additional Information" with a table for "Applications and Visits Recap". This table includes columns for Type, Status - Reason, Work, Applied for Dates, and Next Process. The "Status - Reason" column for the first row is also highlighted with a yellow box, showing "Pending - Application Submitted".

33. If the application type is RSM or Pregnant Woman, go to step 26. Otherwise, all updates have been made and there are no further steps.

Ortega-Ochoa, Yaragua
Page#9644949
DOB: 12/22/95
Age: 28
Gender: F

Adobe eSignature
Text/Email
Person
- Edit
- Financial
Other Applicant
- Add
- Link
Visits
- Add
- Link
Applications

1605 Calvin Davis Cir
LAWRENCEVILLE, GA 30043
County: GWINNETT

470-354-6763 (P)
 Opted Out of Texts
Ochoaortega22@gmail.com
Language: Spanish (P)
Contact Preference: Phone

Other Applicant Info:
Other Applicant: Alexis Garcia-Ortega
DOB: 06/16/17
PersonID: 9649403
Other Applicant: Liam Garcia-Ortega
DOB: 05/15/24
PersonID: 17289375

Additional Information

Applications and Visits Recap				
Type	Status - Reason	Work	Applied for Dates	Next Process
RSM-EMA-05/15/24 (I)	Pending - Application Submitted	09/26/24	05/10/24 - 05/25/24	Contact State Agency
Visit: 05/14/24 (IP)	Northside-OB	2421100011	\$0.00	Pending Approval
Pregnant Woman-EMA-06/17/17 (I)	Approved - Eligibility Found	Work	06/15/17 - 06/30/17	

34. For application types RSM or Pregnant Woman, there may be a baby linked to the application. You can identify that in the upper right corner in PACE. The baby will have a recent date of birth.

Ortega-Ochoa, Yaragua
Page#9644949
DOB: 12/22/95
Age: 28
Gender: F

Adobe eSignature
Text/Email
Person
- Edit
- Financial
Other Applicant
- Add
- Link
Visits
- Add
- Link
Applications

1605 Calvin Davis Cir
LAWRENCEVILLE, GA 30043
County: GWINNETT

470-354-6763 (P)
 Opted Out of Texts
Ochoaortega22@gmail.com
Language: Spanish (P)
Contact Preference: Phone

Other Applicant Info:
Other Applicant: Alexis Garcia-Ortega
DOB: 06/16/17
PersonID: 9649403
Other Applicant: Liam Garcia-Ortega
DOB: 05/15/24
PersonID: 17289375

Additional Information

Applications and Visits Recap				
Type	Status - Reason	Work	Applied for Dates	Next Process
RSM-EMA-05/15/24 (I)	Pending - Application Submitted	09/26/24	05/10/24 - 05/25/24	Contact State Agency
Visit: 05/14/24 (IP)	Northside-OB	2421100011	\$0.00	Pending Approval
Pregnant Woman-EMA-06/17/17 (I)	Approved - Eligibility Found	Work	06/15/17 - 06/30/17	

35. Click the baby name to navigate to the baby's account in PACE

Ortega-Ochoa, Yaragua
Page#9644949
DOB: 12/22/95
Age: 28
Gender: F

Adobe eSignature
Text/Email
Person
- Edit
- Financial
Other Applicant
- Add
- Link
Visits
- Add
- Link
Applications

1605 Calvin Davis Cir
LAWRENCEVILLE, GA 30043
County: GWINNETT

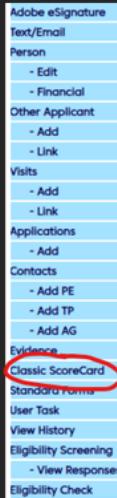
470-354-6763 (P)
 Opted Out of Texts
Ochoaortega22@gmail.com
Language: Spanish (P)
Contact Preference: Phone

Other Applicant Info:
Other Applicant: Alexis Garcia-Ortega
DOB: 06/16/17
PersonID: 9649403
Other Applicant: Liam Garcia-Ortega
DOB: 05/15/24
PersonID: 17289375

Additional Information

Applications and Visits Recap				
Type	Status - Reason	Work	Applied for Dates	Next Process
RSM-EMA-05/15/24 (I)	Pending - Application Submitted	09/26/24	05/10/24 - 05/25/24	Contact State Agency
Visit: 05/14/24 (IP)	Northside-OB	2421100011	\$0.00	Pending Approval
Pregnant Woman-EMA-06/17/17 (I)	Approved - Eligibility Found	Work	06/15/17 - 06/30/17	

36. Follow steps 17 and 18 above, and in the Note field paste the note you copied from the mom's account in PACE, click Save, the close the window. Then, click Save in PACE on the Edit Application page (see step 23)
37. Once the application(s) have been submitted and updated in PACE, you will need check the scorecard and update the application status accordingly.
38. Select Classic Scorecard.



39. Select the Hyperlink next to the State Application that the HCR updated to Application Submitted. This will open up the application Evidence Scorecard

A screenshot of a software interface showing the evidence scorecard for a specific application. The title bar says "MaineCare - Expansion-02/24/25 (Pending - Application Submitted)". Below are five categories: Personal (0), Medical (0), Visit: 23456789 - 02/23/25 (IP) zTest Customer (0), Form (1), and Financial (0). The "Form (1)" section is highlighted with a yellow background.

40. Next you will need to review the **Personal and Financial** evidence scorecard only.

A screenshot of the same evidence scorecard interface as the previous one. The "Personal (0)" and "Financial (0)" sections are highlighted with yellow backgrounds, while the other sections are white.

41. If there are **NO** Personal or Financial evidence listed, or the evidence is listed as **Received or Submitted:**

A screenshot of the evidence scorecard interface. The "Personal (0)" and "Financial (0)" sections are highlighted with yellow backgrounds. The other sections are white.

SMP-03/26/18 (Taken - Not Sent)

Personal (1)
ID-SSN Card <input type="checkbox"/> Received-H 04/06/25 <input type="checkbox"/> APP - Applicant
Medical (0)
Visit: 123453 - 10/25/17 (OP) zTest Customer (0)
Form (0)
Financial (1)
Income Ver-Earned <input type="checkbox"/> Submitted 04/06/25 <input type="checkbox"/> APP - Applicant

42. Go back to the Person Screen and select the Date hyperlink

MaineCare - Disability-02/24/25 (I)	Pending - Application Submitted	04/21/25	12/01/24 - 02/24/26	Contact State Agency
Visit: 02/23/25-02/24/25 (IP)	zTest Customer	23456789	\$3,200.00	Pending Approval

43. This opens the Status Agency Page.

- Under the Select Result drop down, select **Scorecard Review Completed-Documents on File**
- Add the **Scorecard review Completed-Documents on File** canned note
- Select **SAVE - NOTE: this is what you will do for ALL application types of Pregnant Woman, RSM, and RSM-Baby.**

Scorecard Review Completed-Documents on File	a
Detail1	Choose... <input type="button"/>
Detail2	Choose... <input type="button"/>
Hearing Date:	<input type="text"/>
Onset Date:	<input type="text"/>
Allowed Date:	<input type="text"/>
Override Due Date:	<input type="text"/>
Approved Date:	<input type="text"/>
Denied Date:	<input type="text"/>
View Scorecard for this Application	b
Update Agency Representatives	
<input type="button"/> Save	c
<input type="button"/> Cancel	

44. Next, find the note template in the screen shot below.

Pace Notes - Google Chrome
https://pace.changehealthcare.com/PaceNotesFrame.aspx?lURL=https://pace.changehealthcare.com/P...

Note Template

Role Type *	<input type="text"/> HCR	<input type="checkbox"/> Private
Note Template *	<input type="text"/> Scorecard Review Complet...	<input type="checkbox"/> High Importance
<input type="checkbox"/> Add to all active visits ⓘ		
Note *	<input type="text"/> Evidence scorecard reviewed-all documents on file.	
<input type="button"/> Preview <input type="button"/> Cancel <input type="button"/> Save		

45. The application status will update from Application Submitted to Patient Outreach-Scorecard Review Completed-Documents on File

Patient Outreach - Scorecard Review Completed - Documents on File

MaineCare - Disability-02/24/25 (I) 04/21/25 12/01/24 - 02/24/26 Patient Outreach

Visit: 02/23/25-02/24/25 (IP) zTest Customer 23456789 \$3,200.00 Pending Approval

46. If there are Personal and/or Financial evidence listed as Outstanding – NOTE: These steps only applies to AMN and LIM application types.

MaineCare - Non Disability-02/24/25 (Pending - Application Submitted)

- Personal (1)**
 - ID-SSN Card Outstanding 04/06/25 APP - Applicant
- Medical (0)**
- Visit:** 23456789 - 02/23/25 (IP) zTest Customer (0)
- Form (3)**
- Financial (1)**
 - Bank Statements-Checking & Savings Outstanding 04/06/25 APP - Applicant

47. Go back to the Person Screen and select the Date Hyperlink

MaineCare - Disability-02/24/25 (I) Pending - Application Submitted 04/21/25 12/01/24 - 02/24/26 Contact State Agency

Visit: 02/23/25-02/24/25 (IP) zTest Customer 23456789 \$3,200.00 Pending Approval

48. This opens the Status Agency Page.

- Under the Select Result drop down, select **Scorecard Review Completed-Need Evidence**
- Add the **Scorecard Review Completed-Need Evidence** canned note. In the Free Text box, detail the evidence needed.
- Select **SAVE**

MaineCare - Non Disability-02/24/25 (Contact State Agency)

Application Level: Initial
Range Applied for: 02/01/25 - 02/01/25
Previous Activity:
Status: Application Submitted
Application Dates:

Select Result: Scorecard Review Completed - Need Evidence **a**

Detail1: Choose...
Detail2: Choose...

Hearing Date:
Onset Date:
Allowed Date:
Override Due Date:
Approved Date:
Denied Date:

[View Scorecard for this Application](#) [Update Agency Representatives](#)

b **c**

49. Next, find the note template in the screen shot below. In the free form field, type the types of evidence outstanding (found on step 46).

Note Template

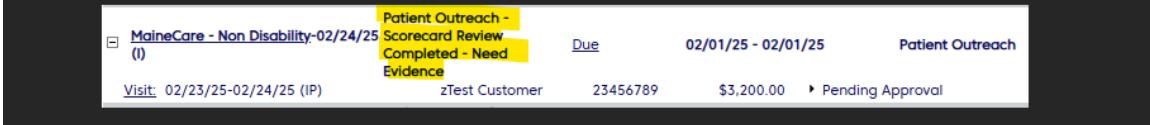
Role Type *
HCR

Note Template *
Scorecard Review Complet... X

Note *
Evidence Scorecard Review Completed-Need Evidence

Preview **Cancel** **Save**

50. The application status will update from Application Submitted to Patient Outreach-Scorecard Review Completed-Need Evidence



c. Enter the username/password information into PACE under Person, click Edit.

Edit Person

Text/Email

Person - Edit

Other Applicant

Visits

Applications

Contacts

Evidence

Classic ScoreCard

Standard Forms

User Task

View History

Eligibility Screening - View Responses

Eligibility Check

SSN: Have

SSN Availability: Have

Client ID:

MedicareID: Add New MedicaidID & State Add New Medicaid

MedicaidID: Please Select

State: Primary

First Name: Middle Name: Last Name:

Birth Date: Birth City: Birth State: Birth Country:

Alias: Gender: Male Female

Height: 0 feet 0 inches Weight: lbs

Mother's First Name: Mother's Middle Name: Mother's Maiden Name: Mother's Last Name: Father's First Name: Father's Middle Name: Father's Last Name: Person Alerts Add New Alert

Person Alert 1: Miscarriage

Person Alert 2: Choose...

Marital Status: Single

Citizenship Status: US Citizen

Educational Level: Choose...

Mailing Address

Address1: Address2: Zip Code: City: State: County: Residential Address Same as mailing

Address1: Address2: Zip Code: City: State: County: Phone Numbers:

Has Patient Agreed to Receive Texts?: Yes No Unknown Sep 16 2025

Has Patient Provided an Email Address?: Yes No Unknown

Email Address: -

Email Address Verified: Yes No

Email Address Verified By: PA Call Center

Contact Preference: Choose...

Time of Day to Contact:

UserName: CHI12680644

Password: 12680644CHI

Security Answer: Optum, Financial, Services

Conditions: