



Georgia Department of Behavioral Health &  
Developmental Disabilities

Kevin Tanner, Commissioner

**D·B·H·D·D**

Region 1 Field Office

**Questions? Contact 678-947-2818 and press 1 for Applications.**

### INFORMATION FOR APPLICANT

I want to extend a Welcome to you from the Region 1 Field Office. We appreciate your request for an Application for Developmental Disability Services. Enclosed with your application are several documents that should help you through the process of gathering information. This information needs to accompany your completed application. Included is the "Application for Developmental Disabilities Services", a List of Information for to you submit with your application packet, and a Release of Information form.

Completed Application Packets include the Application, and copies of the following documents, that pertain to the individual:

- Copy of Birth Certificate or other approved form of documentation to verify Lawful Presence
- Copy of Social Security card or Social Security number;
- Copy of Medicaid and/or Medicare card;
- Copy of Social Security Benefit information;
- Copy of Psychological Evaluations completed by school and/or private Psychologists with signatures;
- Copy of medical, diagnostic or testing report that has been completed by a doctor with signatures;
- Copies of reports with signatures describing your disabilities that may have been completed by schools you attended or by other services agencies, specifically copies of your IEP;
- Copy of guardianship documents (if applicable)

Once you have gathered the above information, please return to:

Department of Behavioral Health and Developmental Disabilities  
Region 1 Field Office  
1230 Bald Ridge Marina Rd, Suite 800  
Cumming, Georgia 30041  
Attn: Intake & Evaluation Unit  
*(Contact our office if you would prefer to send in the documents another way)*

The application process for the Medicaid Waiver for Developmental Disabilities Services begins when our office receives your completed application packet which must include a copy of a Psychological Report(s) and Lawful Presence Verification Documents. Once we have had time to review the application packet submitted, staff from the Region 1 Field Office will be in touch with you about the next step in the process. If you have any questions or need help with filling out the application, don't hesitate to contact our office.

Please feel free to call the Region 1 Field Office at (678) 947-2818, if you have any questions.

Respectfully,

*Elise Beumer, M.S., LPC*

Elise Beumer, LPC  
Regional Services Administrator for Developmental Disabilities

Georgia Department of Behavioral Health & Developmental Disabilities  
Region 1 Field Office

1230 Bald Ridge Marina Road | Suite 800 | Cumming, Georgia 30041 | 678.947.2818 | [dbhdd.georgia.gov](http://dbhdd.georgia.gov)



## NEED FOR DOCUMENTATION

**WHAT WE NEED:** Determining someone's eligibility for services based on a developmental disability can be particularly complicated. Examples of the kinds of records that are most helpful in determining eligibility are:

- Psychological Evaluations
- Individualized Education Plans (IEPs) and other school-based assessments
- Treatment notes that contain diagnoses of Intellectual Disabilities, Autism, or a similar disability
- Professional observations and reports concerning level of intellect (IQ) and adaptive behavior/daily living skills

**WHY WE NEED IT:** We do not want to unfairly deny people of benefits they deserve or make the intake process excessively long and burdensome. But the only way we can establish an individual's eligibility for services is through records that describe how the person was thinking, behaving, and performing as a child or adolescent. These records may be difficult to find and obtain but they are irreplaceable sources of information.

**WHERE TO FIND IT:** The following places may have the kind of information that could help us to establish the existence of a developmental disability:

a) Schools

- Where did the applicant attend school?
- Was there a special education program- an Individualized Education Program (IEP)?
- Are there transcripts showing classes attended?
- Psychological or Psycho-Educational Assessments  
(prior to age 18 for an Intellectual Disability and/or the age of 22 for a Closely Related Condition)

b) Job Training or Vocational Rehabilitation Programs

- Has the applicant ever tried to get help in finding work or applied for a work training program?

c) Social Security Administration Offices

- Has the applicant ever applied for disability benefits? What county was the applicant living in when those benefits were applied for?

**HOW TO GET IT:** There are two ways to get the kinds of records that we need.

1. The applicant or guardian can request the records directly and then send the copies to the Intake and Evaluation Office. Sometimes this method has the fastest response, and it is required for Social Security records.
2. Complete and sign a separate consent form for each individual and/or agency that should be given permission to release information to the Intake and Evaluation Office. Once received in the Intake and Evaluation office, a letter will be sent to the agency specified requesting a copy of the records on the applicant's behalf.
3. Please be sure to send in "**signed**" copies of records.



## Instructions for Intellectual/Developmental Disabilities Services Application

Please use this guide to help you through the application process. Check off each step as it is completed.  
Call your field office (listed below) if you need assistance

1.	Complete the five-page Application for Intellectual/Developmental Disabilities Services.
2.	Please submit copies of the following documents along with the application:
a)	Psychological report that includes IQ score, assessment of Autism Spectrum Disorder ( <i>if applicable</i> ), and adaptive skills testing, preferably completed prior to the age of 18 for a person with intellectual disability or 22 for a person with a closely-related condition.
b)	Proof of citizenship ( <i>birth certificate, passport, or permanent resident card</i> ).
c)	Copy of Social Security card or Social Security number.
d)	Copy of Medicaid and/or Medicare card.
e)	Copy of Social Security benefit information.
f)	Copy of guardianship documents ( <i>if applicable</i> ).
g)	Copy of reports describing the disability, completed by schools attended or by other service agencies ( <i>e.g., IEP</i> ).
h)	Authorization for Release of Information ( <i>requires signature</i> ) if you would like us to request records from a particular agency.
i)	Notice of Privacy Practices ( <i>requires signature</i> ).
3.	Return the application and requested documents to your regional field office.

Once we have determined that a completed application packet has been received by our office, we will contact you and/or your family participant/representative to schedule a screening assessment meeting within 14 business days.

<b>Region 1 Field Office</b> Intake & Evaluation Unit 1230 Bald Ridge Marina Rd, Ste 800 Cumming, GA 30041 (678) 947-2818 or (877) 217-4462 <b>FAX: (678) 947-2817</b>	<b>Region 2 Field Office</b> Intake & Evaluation Unit 3405 Mike Padgett Hwy, Bldg 3 Augusta, GA 30906 (706) 792-7741 or (877) 551-4897 <b>FAX: (706) 792-7740</b>	<b>Region 3 Field Office</b> Intake & Evaluation Unit 3073 Panthersville Rd, Bldg 10 Decatur, GA 30034 (404) 244-5050 or (404) 244-5056 <b>FAX: (404) 244-5179</b>
<b>Region 4 Field Office</b> Intake & Evaluation Unit PO Box 1378 Thomasville, GA 31799-1378 (229) 225-5099 or (877) 683-8557 <b>FAX: (229) 227-2918</b>	<b>Region 5 Field Office</b> Intake & Evaluation Unit 1915 Eisenhower Drive, Bldg 7 Savannah, GA 31406 (912) 303-1649 or (800) 348-3503 <b>FAX: (912) 351-6309</b>	<b>Region 6 Field Office</b> Intake & Evaluation Unit 3000 Schatulga Rd, Bldg 4 Columbus, GA 31907-2435 (706) 565-7835 or (877) 565-8040 <b>FAX: (706) 565-3565</b>



### DBHDD REGIONAL FIELD OFFICE JURISDICTION (COUNTY)

#### Region 1 Field Office (North Georgia)

Banks	Bartow	Catoosa	Chattooga	Cherokee	Cobb
Dade	Dawson	Douglas	Fanin	Floyd	Forsyth
Franklin	Gilmer	Gordon	Habersham	Hall	Haralson
Hart	Lumpkin	Murray	Paulding	Pickens	Polk
Rabun	Stephens	Towns	Union	Walker	White
Whitfield					

#### Region 2 Field Office (East Central Georgia)

Baldwin	Barrow	Bibb	Burke	Clarke	Columbia
Elbert	Emanuel	Glascok	Greene	Hancock	Jackson
Jasper	Jefferson	Jenkins	Jones	Lincoln	Madison
McDuffie	Monroe	Morgan	Oconee	Oglethorpe	Putnam
Richmond	Screven	Taliaferro	Twiggs	Walton	Warren
Washington	Wilkes	Wilkinson			

#### Region 3 Field Office (Metro Atlanta)

Clayton	DeKalb	Fulton	Gwinnett	Newton	Rockdale
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#### Region 4 Field Office (Southwestern Georgia)

Baker	Ben Hill	Berrien	Brooks	Calhoun	Colquitt
Cook	Decatur	Dougherty	Early	Echols	Grady
Irwin	Lanier	Lee	Lowndes	Miller	Mitchell
Seminole	Terrell	Thomas	Tift	Turner	Worth

#### Region 5 Field Office (Southeastern Georgia)

Appling	Atkinson	Bacon	Bleckley	Brantley	Bryan
Bulloch	Camden	Candler	Charlton	Chatham	Clinch
Coffee	Dodge	Effingham	Evans	Glynn	Jeff Davis
Johnson	Laurens	Liberty	Long	McIntosh	Montgomery
Pierce	Pulaski	Tattnall	Telfair	Toombs	Treutlen
Ware	Wayne	Wheeler	Wilcox		

#### Region 6 Field Office (West Central Georgia)

Butts	Carroll	Chattahoochee	Clay	Coweta	Crawford
Crisp	Dooly	Fayette	Harris	Heard	Henry
Houston	Lamar	Macon	Marion	Meriwether	Muscogee
Peach	Pike	Quitman	Randolph	Schley	Spalding
Stewart	Sumter	Talbot	Taylor	Troup	Upton
Webster					



# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Personal Details

All fields marked \* are required

First Name \*

M.I.

Last Name \*

Suffix (select one)

JR.  SR.  II  III

Maiden or Birth Surname

Preferred Name

Date of Birth (MMDDYYYY) \*

Gender (select one) \*

Male  Female  
 Transgender Male to Female  
 Transgender Female to Male  
 Other/Unknown

Marital Status (select one) \*

Single  Separated  
 Married  Widowed  
 Divorced  Unknown/Refused  
 Partnered

Race (select one) \*

American Indian/Alaskan Native  
 Black/African American  
 White/Caucasian  
 Asian

Multiracial  
 Other Single Race  
 Unknown/Refused

Hispanic/Latino Origin (select one) \*

Yes  
 No  
 Unknown/Refused

SSN \*

SSN

Not Available

Medicare #

Medicaid #

or Application Date

Current Living Situation

Primary Phone Number \*

Secondary Phone Number

Email Address

Confirm Email Address

Street Address \*

Apt/Unit/Suite or Other Address

City \*

State \*

Zip \*

County of Residence \*

Is the Applicant Lawfully Present in the United States?

Yes  No  N/A (e.g. individual is under 18)  Unknown/Refused

Is the Applicant a Veteran?

Yes  No  Unknown/Refused

Check here if mailing Address is same as above

Mailing Street Address or PO Box

Mailing Apt/Unit/Suite or Other Address

Mailing City

Mailing State

Mailing Zip

County of Residence

### PRIMARY CONTACT DETAILS

Primary Contact First Name

M.I.

Primary Contact Last Name

Suffix (select one)

JR.  SR.  II  III

Relation to Applicant

Primary Contact Age

Email Address

Primary Phone Number

Secondary Phone Number

Street Address

Apt/Suite or Other Address Info

City

State

Zip

County of Residence



# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Legal Status and Guardian

All fields marked \* are required

What is the legal status of the Applicant?

- Competent
- Emancipated
- Legally Incompetent: Documentation Required\*
- Minor
- Unknown

**\*It is mandatory to fill in Legal Guardian details for individuals with a Court appointed guardian.  
Note: Guardianship Order from a Georgia Probate Court must be attached**

Is Legal Guardian a \*

- Person                       Agency

Legal Guardian or Caseworker First Name \*

Legal Guardian Caseworker Last Name \*

Suffix (select one)

- JR.    SR.    II    III

M.I.

Legal Guardian Email

Relationship to Applicant (select one) \*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Case Worker       | <input type="checkbox"/> In-Law Relative     | <input type="checkbox"/> School                    |
| <input type="checkbox"/> Child             | <input type="checkbox"/> Neighbor            | <input type="checkbox"/> Sibling                   |
| <input type="checkbox"/> Counselor/Teacher | <input type="checkbox"/> Other Family Member | <input type="checkbox"/> Spouse/Significant Other  |
| <input type="checkbox"/> Friend            | <input type="checkbox"/> Parent              | <input type="checkbox"/> Substitute Decision-Maker |
| <input type="checkbox"/> Grandparent       | <input type="checkbox"/> Roommate            | <input type="checkbox"/> Other                     |

Legal Guardian Phone Number \*

Legal Guardian Phone Extension

Check here if Legal Guardian's Address is the same as the Applicant

Legal Guardian Street Address or PO Box

Apt/Unit/Suite or Other Address

City

State

Zip

County of Residence



# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Communication

All fields marked \* are required

#### English Proficiency (select one)

- Very Well
- Well
- Not Well
- Not at All
- Unknown/Refused

#### Does the Applicant prefer to speak or use a language other than English? \*

- Yes
- No
- Unknown/Refused
- Preferred Language \_\_\_\_\_

#### What mode of communication does the Applicant utilize? (select all that apply) \*

- Communicates verbally (regardless of proficiency)
- Communication Aids (any type of device used for communication)
- American Sign Language (ASL)
- Other Manual Communication (cued speech; gestures; signed exact English; other signed languages; etc.)
- Other Communication

#### Preferred Mode of Communication (select an option) \*

- Communicates verbally (regardless of proficiency)
- Communication Aids (any type of device used for communication)
- American Sign Language (ASL)
- Other Manual Communication (cued speech; gestures; signed exact English; other signed languages; etc.)
- Other Communication

### Hearing

#### Is the Applicant deaf or does the Applicant have serious difficulty hearing? \*

- Yes
- No
- Unknown/Refused

#### Is there indication from sources other than the Applicant (e.g. third-party report; interviewer's observation; medical records, etc.) that the Applicant has hearing loss?

- Yes
- No
- Unknown/Refused

### Vision

#### Is the Applicant blind or does the Applicant have serious difficulty seeing, even when wearing glasses/contacts? \*

- Yes
- No
- Unknown/Refused



# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### IDD Diagnosis

All fields marked \* are required

Does the Applicant have a confirmed Intellectual and/or Developmental Disability Diagnosis?

- Yes       No       Unknown/Refused

### Referral/Resources

Select Applicant Referral Source \*

Referral Source Name \*

Current Resources Selection \*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Adoption Assistance                      | <input type="checkbox"/> HIPP (Health Insurance Premium Payment Prog) | <input type="checkbox"/> Railroad Benefits   |
| <input type="checkbox"/> CAPS (Subsidized Child Care Assist)      | <input type="checkbox"/> Housing Assistance (Section 8, HPRP)         | <input type="checkbox"/> SOURCE (Source Options Using Resources in a Comm Environment) |
| <input type="checkbox"/> CBAY (Comm Based Alternatives for Youth) | <input type="checkbox"/> ICWP (Independent Care Waiver Prog)          | <input type="checkbox"/> SSDI  |
| <input type="checkbox"/> CCSP (Comm Care Services Prog)           | <input type="checkbox"/> MAO (Medical Assistance Only)                | <input type="checkbox"/> SSI   |
| <input type="checkbox"/> Deeming Waiver (Katie Beckett)           | <input type="checkbox"/> Medicaid                                     | <input type="checkbox"/> TANF (Temp Assist for Needy Families)                         |
| <input type="checkbox"/> Employment                               | <input type="checkbox"/> Medicare                                     | <input type="checkbox"/> Ticket to Work  |
| <input type="checkbox"/> Food Stamps (SNAP)                       | <input type="checkbox"/> PASS (Plan for Achieving Self Sup)           | <input type="checkbox"/> Veterans Assistance/Benefits                                  |
| <input type="checkbox"/> FQHC (Federally Qualified Health Ctr)    | <input type="checkbox"/> PeachCare for Kids                           | <input type="checkbox"/> Vocational Rehabilitation                                     |
| <input type="checkbox"/> GAPP (Georgia Pediatric Prog Waiver)     | <input type="checkbox"/> Private Insurance                            | <input type="checkbox"/> Other   |

Applicant's Monthly Gross Income \*

### Physician Details

All fields marked \* are required

Physician Name

Email

Street Address/PO Box

Apt/Unit/Suite or Other Address Info

City

State

Zip

Phone Number

Phone Extension

Fax Number





# Georgia Department of Behavioral Health and Developmental Disabilities

## Application for Intellectual/Developmental Disabilities Services

### Application Supporting Documents

All fields marked \* are required

Please ATTACH supporting documentation to verify Medicaid eligibility, lawful presence, and a qualifying diagnosis or condition. An application is complete for DBHDD review when required documents are received by mail or documents are attached to accompany the web application.

#### Document Type

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Birth Certificate or Permanent Resident Card * | <input type="checkbox"/> Other Medical or Diagnostic Reports | <input type="checkbox"/> Social Security Benefit Letter *                     |
| <input type="checkbox"/> Developmental Evaluation                       | <input type="checkbox"/> Psychological Evaluation *          | <input type="checkbox"/> Social Security Card *                               |
| <input type="checkbox"/> Medicaid *                                     | <input type="checkbox"/> School IEP Report *                 | <input type="checkbox"/> Vocational/Support Employment Records                |
| <input type="checkbox"/> Medicare Card (if applicable) *                | <input type="checkbox"/> School Transcript                   | <input type="checkbox"/> Release of Information and/or Guardianship Documents |

*If the applicant does not have social security card, Medicaid or Medicare, documentation of lawful presence can include: a birth certificate or unexpired permanent resident card. A description of documentation of lawful presence can be found at: <http://www.mmis.georgia.gov>. To access this information, please point to the 'provider information' menu and select 'provider manuals'. The criteria can be found in the 'Comprehensive Supports Waiver Program Part II manual.'*

### Application Signature

All fields marked \* are required

<b>Last Name</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

#### Application Completed By

- Applicant  
  Guardian  
  Family Member  
  Other (agency, etc.) \_\_\_\_\_

#### Printed Name

\_\_\_\_\_

#### Please indicate the preferred method of contact

- Email Address                       Phone

Email Address

Primary Phone Number

\_\_\_\_\_



Georgia Department of Behavioral Health &  
Developmental Disabilities

Kevin Tanner, Commissioner

**DBHDD**

Region 1 Field Office

**IMPORTANT INFORMATION REGARDING THE  
FOLLOWING DOCUMENTS PERTAINING TO  
GUARDIANSHIP STATUS**

**If an "Individual" is applying for services and age 18 or over and there are no Legal Letters of Guardianship Documents for the State of Georgia, that "Individual" must sign (or make their mark) and initial the forms where indicated.**

**Authorizations for Release of Information (ROI) - *Please see the sample documents and fill out accordingly.***

**Notice of Privacy Practices Form (NPP)**

**Please contact the office if you have any questions - 678-947-2818**

**Thank you.**



SAMPLE

Georgia Department of Behavioral Health & Developmental Disabilities

John Smith

Name of Individual/Consumer/Patient/Applicant 3/4/1985

Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION - STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: The agency/organization/person that you want us to receive information from

(Name of health care provider holding the information - releasing agency)

To: DBHDD Region 1 Field Office, 1230 Bald Ridge Marina Road, Suite 800, Cumming, GA 30041

(Name of Person or Agency to whom information should be given - requesting agency) 678-947-2818 Fax: 678 947 2817

(Address)

(Phone/Fax)

I authorize the following information from my records (and any specific portion thereof): Medical Records, and/or Psychological/Psychoeducational Evaluations, IEPs, Transcripts

Initials

Initial All

I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor, my parent/guardian/court-ordered custodian and I BOTH must initial here in order for this information to be released.

Initials

Initials

I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus) and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

Initials

The above disclosure of information is for the purpose of: Medicaid NOW COMP Waiver Eligibility

- 1. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).
2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.
3. I understand that DBHDD or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.
4. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

Check Box>>>> [ ] one (1) year OR [ ] 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 revoke this authorization at any time as shown in the space below.

If the individual is over 18 and there are no legal guardianship records from the State of GA, the individual must sign and initial where indicated.

Signature of Individual/Consumer/Patient/Applicant

Print Name

Date

OR Signature of other person authorized to sign for Individual (check one):

Print Name

Date

[ ] Parent [ ] Guardian [ ] Court-appointed Custodian of Minor

[ ] Agent designated by Individual's advance directive



Name of Individual/Consumer/Patient/Applicant

Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION – STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: (Name of health care provider holding the information - releasing agency)

(Address) (Phone/Fax)

To: Dept of Behavioral Health & Developmental Disabilities PH: 678-947-2818

(Name of Person or Agency to whom information should be given - requesting agency)

1230 Bald Ridge Marina Rd, Ste. 800, Cumming, GA 30041 Fax:678-947-2817

(Address)

(Phone/Fax)

I authorize the following information from my records (and any specific portion thereof):

Initials

I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor, my parent/guardian/court-ordered custodian and I BOTH must initial here in order for this information to be released.

Initials

Initials

I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus) and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

Initials

The above disclosure of information is for the purpose of:

Medicaid NOW COMP Waiver Eligibility

- 1. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).
2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.
3. I understand that DBHDD or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.
4. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

[ ] one (1) year OR [ ] 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 revoke this authorization at any time as shown in the space below.

Signature of Individual/Consumer/Patient/Applicant Print Name Date Time am/pm

OR Signature of other person authorized to sign for Individual(check one): Print Name Date Time am/pm

[ ] Parent [ ] Guardian [ ] Court-appointed Custodian of Minor

[ ] Agent designated by Individual's advance directive

**USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN**

*I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to DBHDD's Privacy Officer at 2 Peachtree St. NW, Suite 22.250 Atlanta, GA 30303-3142.*

\_\_\_\_\_  
Date this authorization is revoked

\_\_\_\_\_  
Time am/pm

\_\_\_\_\_  
Signature of Individual or Legally Authorized Representative

**Complaints and Additional Information:** All complaints may be made to DBHDD and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with your DBHDD facility or program, or with your treatment provider or services provider under contract or agreement with DBHDD's Office of Constituent Services which maintains your protected health information at telephone **(888) 785-6954**, fax number **(770) 408-5439**, by mail to **2 Peachtree Street, NW, Suite 24-473 Atlanta, Georgia 30303**, or email <http://dbhdd.georgia.gov/office-constituent-services>. You must state the basis for your complaint. Neither the facility, the provider, nor DBHDD will retaliate against you for filing a complaint. You may also obtain additional information about privacy practices from this contact person.

You may also contact **DBHDD's Privacy Officer by telephone at (404) 232-1174, fax number (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.244, Atlanta Georgia, 30303-3142**, for further information about the complaint process or about this notice.

\_\_\_\_\_  
Signature of Individual or Legally Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time am/pm



**NOTICE OF NONDISCRIMINATION:**

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. DBHDD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. To communicate effectively with us, DBHDD provides to people with disabilities free aids and services such as interpreters; and written information in other formats (large print, audio, accessible electronic formats). To communicate effectively with us, DBHDD provides to people whose primary language is not English free language services such as interpreters and information written in other languages. If you need these services, contact Constituent Services at 404-657-5964 or 888-785-6954.

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (404.657.5964 or 888.785.6954)

**ध य न दः य द आप ह द बोलत ह तो ो आपक लए म त म भ ष सह यत स व ए उपलब् ध ह ।**  
(404.657.5964 or 888.785.6954)

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (404.657.5964 or 888.785.6954)

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (404.657.5964 or 888.785.6954)

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용하실 수 있습니다.  
(404.657.5964 or 888.785.6954) 번으로 전화해 주십시오.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (404.657.5964 or 888.785.6954).

**注意 :** 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 (404.657.5964 or 888.785.6954).

**ملحوظة:** إذا كنت تتحدث أحدى اللغات، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل (404.657.5964 or 888.785.6954)

**કચુ ના:** જો તમે જુ રાતી બોલતા હો, તો િો ન: લ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો  
(404.657.5964 or 888.785.6954).

**ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (404.657.5964 or 888.785.6954).

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (404.657.5964 or 888.785.6954).

**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما با باشد می فراهم (404.657.5964 or 888.785.6954)

**ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ለየግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ (404.657.5964 or 888.785.6954)

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まで、お電話にてご連絡ください。



SAMPLE

Georgia Department of Behavioral Health & Developmental Disabilities

If no legal guardianship records from St. of GA. with this form, the individual gives permission for someone to speak their behalf.

John Smith

Name of Individual/Consumer/Patient/Applicant 3/4/1985

Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION - STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: DBHDD Region 1 Field Office

(Name of health care provider holding the information - releasing agency) 1230 Bald Ridge Marina Road, Suite 800, Cumming, GA 30041 678-947-2818 FAX: 678-947-2817

To: Name of Family Member and/or: Other Relative, Teacher, Translator, Friend, Social Worker, etc.

(Name of Person or Agency to whom information should be given - requesting agency)

(Address)

(Phone/Fax)

JS I authorize the following information from my records (and any specific portion thereof): All that pertain to the eligibility determination for the Medicaid NOW COMP Waiver

JS I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor, my parent/guardian/court-ordered custodian and I BOTH must initial here in order for this information to be released.

JS I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus) and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

The above disclosure of information is for the purpose of: Medicaid NOW COMP Waiver Eligibility

- 1. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).
2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.
3. I understand that DBHDD or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.
4. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

Check Box >> [ ] one (1) year OR [ ] 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 revoke this authorization at any time as shown in the space below.

Signature of Individual/Consumer/Patient/Applicant NOT APPLICABLE XXXXXXXXXXXXXXXX OR Signature of other person authorized to sign for Individual (check one): [ ] Parent [ ] Guardian [ ] Court-appointed Custodian of Minor [ ] Agent designated by Individual's advance directive

John Smith 2/18/19

Print Name N/A Date N/A

Print Name Date



DBHDD

Georgia Department of Behavioral Health & Developmental Disabilities

Name of Individual/Consumer/Patient/Applicant

Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION – STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: GA Dept. of Behavioral Health and Developmental Disabilities 678-947-2818
(Name of health care provider holding the information - releasing agency)
1230 Bald Ridge Marina Rd Suite 800, Cumming GA 30041 Fax 678-947-2817
(Address) (Phone/Fax)

To:
(Name of Person or Agency to whom information should be given - requesting agency)
(Address) (Phone/Fax)

I authorize the following information from my records (and any specific portion thereof):

Initials For Medical NOW COMP Waiver Eligibility and Processes

I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor, my parent/guardian/court-ordered custodian and I BOTH must initial here in order for this information to be released.

Initials

I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus) and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

Initials

The above disclosure of information is for the purpose of:

Medicaid NOW COMP Waiver Eligibility and Processes

- 1. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).
2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.
3. I understand that DBHDD or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.
4. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

[ ] one (1) year OR [ ] 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 revoke this authorization at any time as shown in the space below.

Signature of Individual/Consumer/Patient/Applicant Print Name Date Time am/pm

OR Signature of other person authorized to sign for Individual(check one): Print Name Date Time am/pm

[ ] Parent [ ] Guardian [ ] Court-appointed Custodian of Minor

[ ] Agent designated by Individual's advance directive



**USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN**

*I hereby revoke this authorization, and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to DBHDD's Privacy Officer at 2 Peachtree St. NW, Suite 22.250 Atlanta, GA 30303-3142.*

\_\_\_\_\_  
Date this authorization is revoked

\_\_\_\_\_  
Time am/pm

\_\_\_\_\_  
Signature of Individual or Legally Authorized Representative

**Complaints and Additional Information:** All complaints may be made to DBHDD and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with your DBHDD facility or program, or with your treatment provider or services provider under contract or agreement with DBHDD's Office of Constituent Services which maintains your protected health information at telephone **(888) 785-6954**, fax number **(770) 408-5439**, by mail to **2 Peachtree Street, NW, Suite 24-473 Atlanta, Georgia 30303**, or email <http://dbhdd.georgia.gov/office-constituent-services>. You must state the basis for your complaint. Neither the facility, the provider, nor DBHDD will retaliate against you for filing a complaint. You may also obtain additional information about privacy practices from this contact person.

You may also contact **DBHDD's Privacy Officer by telephone at (404) 232-1174, fax number (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.244, Atlanta Georgia, 30303-3142**, for further information about the complaint process or about this notice.

\_\_\_\_\_  
Signature of Individual or Legally Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time am/pm



DBHDD

**NOTICE OF NONDISCRIMINATION:**

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. DBHDD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. To communicate effectively with us, DBHDD provides to people with disabilities free aids and services such as interpreters; and written information in other formats (large print, audio, accessible electronic formats). To communicate effectively with us, DBHDD provides to people whose primary language is not English free language services such as interpreters and information written in other languages. If you need these services, contact Constituent Services at 404-657-5964 or 888-785-6954.

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (404.657.5964 or 888.785.6954)

**धुनदः यद आप हद बोलत ह तो आपक लए म त म भ ष सह यत स व ए उपलब्ध ह।**  
(404.657.5964 or 888.785.6954)

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (404.657.5964 or 888.785.6954)

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (404.657.5964 or 888.785.6954)

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.  
(404.657.5964 or 888.785.6954) 번으로 전화해주십시오.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (404.657.5964 or 888.785.6954).

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**કુ યુ ના:** જો તમે જુ રાતી બોલતા હો, તો િ ં ન: ક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો  
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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما با یاضد می فراهم (404.657.5964 or 888.785.6954)

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まで、お電話にてご連絡ください。

**Georgia Department of Behavioral Health  
& Developmental Disabilities**

**NOTICE OF PRIVACY PRACTICES FORM**  
Per DBHDD Policy 23-101

Facility/Program/Hospital Name: DBHDD Region 1 Field Office  
Address, City, State, Zip: 1230 Bald Ridge Marina Rd, Ste. 800, Cumming, GA 30041  
Contact numbers: 678-947-2818 Fax: 678-947-2817

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. It is provided to you under the Health Insurance Portability and Accountability Act of 1996 and related federal regulations (together referred to as "HIPAA") and provides some additional information about other federal and state confidentiality protections. If you have questions about this Notice please contact the facility where you receive services (your treatment provider or services provider) or DBHDD's Privacy Officer at the address below.**

DBHDD is an agency of the State of Georgia responsible for certain programs which deal with medical, mental health, developmental disabilities, addictive disease, and other confidential information. DBHDD must comply with strict requirements of federal and state laws regarding confidential information. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how DBHDD may use and disclose your "protected health information" for treatment, payment, health care operations, and certain other purposes. This notice also describes your rights regarding your protected health information. **Protected Health Information** is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services, and payment for services. DBHDD is also required to provide you this Notice of Privacy Practices, and to abide by its terms. DBHDD may change the terms of this notice at any time. A new notice will be effective for all protected health information that DBHDD maintains at the time of issuance. DBHDD will provide you with any revised Notice of Privacy Practices by posting copies at its facilities, publication on DBHDD's website, in response to a telephone or facsimile request to the Privacy Officer, or in person at any facility where you receive services.

**1. Your Rights:** The following is a statement of your rights about your protected health information and how you may exercise these rights. If you have a court-appointed guardian, your guardian may exercise these rights for you; if you are a minor, your parent or court-appointed custodian may exercise these rights for you; your healthcare agent in a valid advance directive may exercise these rights for you if your advance directive says so. To exercise any of these rights, you may contact the staff person named in Section 7 below, at your treatment provider's location, or your treatment provider's HIPAA Coordinator.

**a. You have the right to inspect and copy your Protected Health Information:** You may inspect and obtain a copy of protected health information about you for as long as DBHDD maintains the protected health information. This information includes medical and billing records and other records DBHDD uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information. While you are hospitalized, your physician may restrict your right to review your records if it may endanger your life or physical safety. If your protected health information was obtained or created in the course of research that includes treatment, your right to access that protected health information may be restricted while the research is in progress, if you agreed to this restriction in advance.

**b. You have the right to request restriction of your Protected Health Information:** You may ask DBHDD not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your care. Your request must be in writing, and it must state the specific restriction you are requesting and to whom you want the restriction to apply. DBHDD is not required to agree to a restriction you request, and DBHDD may not prevent disclosures to the Secretary of Health and Human Services or any disclosure that is required by law. If DBHDD believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If DBHDD does agree to your request, DBHDD may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. DBHDD must agree to a restriction if you request to restrict

disclosure of your protected health information to a health plan when: (1) the disclosure is for the purpose of payment or health care operations and is not otherwise required by law; AND (2) the protected health information is about only a health care item or service for which you, or a person other than a health plan on your behalf, have paid DBHDD in full.

**c. You have the right to request to receive confidential communications from us, including billing and payment information, by alternative means or at an alternative location:** If you request it in writing, DBHDD will agree to reasonable requests for alternative means for sending confidential information to you. Your request must tell us how or where you wish to be contacted, or provide an alternative means of payment if necessary. DBHDD will not ask you the reason for your request.

**d. You have the right to request amendment of your Protected Health Information:** If DBHDD created your protected health information; you may request an amendment of that information for as long as it is kept by or for DBHDD. DBHDD may deny your request, and if it does so will provide information as to any further rights you may have about the denial.

**e. You have the right to receive an accounting of certain disclosures DBHDD has made of your Protected Health Information:** You have the right to receive legally specified information about disclosures of your protected health information that DBHDD made in the six (6) years before your request, with certain exceptions, restrictions and limitations. This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, and does not apply to any disclosures DBHDD made to you; to family members or friends or representatives, as defined in the Georgia Mental Health Code, who are involved in your care; to anyone based on written authorization by you (or by your guardian, parent or court-appointed custodian, or healthcare agent as applicable); or for national security, intelligence or notification purposes.

**f. Notice of Breach.** DBHDD has put in place reasonable policies and procedures to protect the privacy and security of your protected health information. DBHDD will notify you, as required by law, if there is an unauthorized acquisition, access, use or disclosure of your protected health information. The law may not require notice to you in all cases.

**f. You have the right to obtain a paper copy of this notice from DBHDD,** upon request at any time. You can also find this Notice on our website, <http://dbhdd.georgia.gov/>.

**2. Uses and Disclosures of Protected Health Information:** DBHDD, its administrative and clinical staff and others involved in your care and treatment, may use and disclose your protected health information to provide health care services to you, and in obtaining payment of your health care bills.

**a. Treatment:** DBHDD may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a current, former, or identified future third party provider. For example, we may disclose your treatment or services plan to a health care professional who is treating you, or who is named in your Individualized Recovery Plan or Individualized Service Plan and will be your provider upon your discharge or transition; to a jail or corrections facility if you are under criminal charges and discharged to jail or corrections; or to another health care provider such as a specialist or laboratory.

**b. Payment:** DBHDD may use and disclose your protected health information to obtain payment for your health care services. For example, your health insurance plan may require protected health information about you to make a determination of eligibility or coverage, or to review services provided to you for medical necessity, before your health insurance plan approves or pays for your health care services. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in obtaining payment; business associates and any subcontractors they may have are also required by law to keep your protected health information confidential.

**c. Health Care Operations:** DBHDD may use or disclose your protected health information for the business activities of DBHDD, including, for example, but not limited to, quality assessment activities, employee review activities, training, and licensing activities. We may also use your protected health information to contact you about appointments or for other operational reasons. DBHDD may also use or disclose your protected health information to third party "business associates" who perform various activities that assist us in providing services to you. Some examples of our business associates might include, but are not limited to, the Georgia Collaborative ASO for care management and the Georgia Crisis Access Line for access to crisis or non-crisis services and referrals. Business associates and any subcontractors they may have are also required by law to keep your protected health information confidential.

**d. Your Representatives:** If you are in a DBHDD hospital, you are allowed to name a representative to receive certain protected health information about you, or DBHDD must name a representative for you if you do not name one. DBHDD will also name a second representative for you, according to Georgia law. DBHDD is not required to seek your authorization in order to inform your representatives of your admission to the hospital, and of your discharge. Unless there is an emergency, you will have a chance to object to other disclosures to your representatives about the development of your Individualized Recovery Plan (IRP) for behavioral health treatment or services, your treatment under the IRP, and certain substantial changes to your IRP.

### **3. You May Authorize or Object To Certain Other Permitted or Required Uses and Disclosures of Your Protected**

**Health Information:** Your protected health information, including clinical records of treatment for mental illness or addictive disease or services relating to developmental disability, is protected by confidentiality under state law. DBHDD is permitted to make certain disclosures described in Section 2 above and in Sections 4 and 5 below, without your authorization or opportunity to object. Other uses and disclosures of your protected health information will be made only if DBHDD has written authorization signed by you (or if you have one, your guardian, parent or legal custodian if you are a minor, or your healthcare agent if you have an advance directive currently in effect). Your written authorization may be revoked at any time. DBHDD will not be able to retract any disclosures of your protected health information that were previously authorized. DBHDD may disclose all or part of your protected health information when authorized in writing.

**a. Confidentiality of Alcohol and Drug Abuse Patient Records:** The confidentiality of patient records which disclose any information identifying you as an alcohol or drug abuser is protected by federal law and regulations. This information generally will not be disclosed unless you consent in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of these federal laws and regulations by the facility, treatment or service provider, or DBHDD, is a crime. You may report violations to appropriate authorities in accordance with the federal regulations. Federal regulations do not protect any information about a crime committed by you either at a facility or program or against any person who works at a facility or program, or information about any threat to commit such a crime. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State agency and local law enforcement authorities.

**b. HIV or AIDS Confidential Information:** Although HIV infection is required to be reported or disclosed in some circumstances under state law, AIDS confidential information, including HIV status or testing information is generally confidential under state law. Other than required disclosures listed at 4.d. below, DBHDD will not disclose AIDS confidential information without your authorization.

**c. Psychotherapy Notes:** Authorization is required for use or disclosure of psychotherapy notes not maintained in your medical record. This authorization may not be required for disclosure of psychotherapy notes about you to the criminal court and attorneys if a DBHDD hospital or its outpatient team is evaluating your mental status to go to trial on criminal charges, or evaluating your mental status at the time you committed a criminal act.

**d. Health Information Networks or Exchanges:** Health information exchanges allow health care providers, including DBHDD, to share and receive health information about individuals receiving our services, which helps in the coordination of your care. DBHDD participates in health information networks that can make your protected health information available electronically to your other providers who are members of the networks. For individuals who have signed an authorization to allow sharing of their protected health information (including alcohol or drug treatment or services information they may have) with their other providers, DBHDD shares protected health information electronically with those other Health Information Exchange members through the Georgia Health Information Network (GaHIN).

**e. Complaints About Your Treatment:** If DBHDD receives a complaint about your treatment or services, such as from your representative or family member, DBHDD will not disclose your protected health information to that person in response to the complaint, unless you have signed an authorization for us to disclose your protected health information.

**f. Marketing and Fundraising:** If DBHDD wishes to use your protected health information for fundraising (for instance, to put your name on a mailing list for requesting a donation to patient benefit funds), or for marketing (for instance, to advertise our treatments and services by using your protected health information) we will first request your written authorization.

**4. Permitted or Required Uses and Disclosures Without Your Authorization or Opportunity to Object:** DBHDD may use or disclose your protected health information without your authorization when the law allows it or requires it.

**a. Persons Involved In Your Care:** DBHDD can use or disclose your protected health information without your authorization, to your court-appointed guardian, if you have a guardian; to your parent or court-appointed custodian if you are a minor, or to your healthcare agent that you have named in an advance directive that is currently in effect.

**b. Regarding Your Health Care:** DBHDD can use or disclose your protected health information without your authorization, to a health care professional or facility that is named in your Individualized Recovery Plan or Individualized Services Plan, for continuity of your care; to an emergency services provider when clinically required; and in hearings regarding your hospitalization or commitment to the hospital. If you were admitted to a DBHDD facility involuntarily, DBHDD can give notice to the healthcare provider or court that referred you to the hospital, if you transfer to voluntary status or when you are discharged. DBHDD can disclose your protected health information to a health oversight agency, for instance, for audits, investigations, inspections and licensure of a DBHDD facility or program.

**c. Legal Requirements:** DBHDD may use or disclose your protected health information without your authorization when required to do so by law, to a law enforcement authority or other state agency authorized to receive reports of abuse or neglect. DBHDD may be required by law to use or disclose your protected health information such as by court order in a lawsuit. If we receive a subpoena for your protected health information, we will either notify you of the subpoena, or we will ask the attorney seeking your records to get a protective order for the confidentiality of your protected health information. In the event of your death, DBHDD may use or disclose your protected health information to a coroner or medical examiner in Georgia, an organ or tissue donation organization, and to the legal representative of your estate.

**d. HIV or AIDS Confidential Information and Other Reportable Diseases:** Georgia law requires DBHDD to report to the Georgia Department of Public Health if you have a disease that is reportable for the protection of public health. This includes HIV infection and other diseases. If you are HIV-positive, DBHDD may also disclose this information in certain circumstances to protect persons at risk of infection by you, including your family and health care providers. DBHDD may also disclose HIV testing or diagnosis information in certain circumstances if we petition the court for an order committing you for involuntary hospitalization or in related legal proceedings. Otherwise, HIV/AIDS information is confidential. See also section 3.b., above.

**5. Required Uses and Disclosures:** Under the law, DBHDD must make certain disclosures to you, and to the Secretary of the United States Department of Health and Human Services when required to investigate or determine DBHDD's compliance with HIPAA requirements.

**6. Practices Not Followed by DBHDD:**

- a. DBHDD does not sell protected health information of any individual.
- b. DBHDD facilities do not maintain directories of admissions.

**7. Complaints and Additional Information:** You may complain to DBHDD and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with your DBHDD facility or program, or with your treatment provider or services provider under contract or agreement with DBHDD's Office of Constituent Services which maintains your protected health information at telephone **(888) 785-6954**, fax number **(770) 408-5439**, by mail to **2 Peachtree Street, NW, Suite 24-473 Atlanta, Georgia 30303**, or email <http://dbhdd.georgia.gov/office-constituent-services>. You must state the basis for your complaint. Neither the facility, the provider, nor DBHDD will retaliate against you for filing a complaint. You may also obtain additional information about privacy practices from this contact person.

You may also contact **DBHDD's Privacy Officer by telephone at 404-232-1174, fax number (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.244, Atlanta Georgia, 30303-3142**, for further information about the complaint process or about this notice.

Please sign a copy of this Notice of Privacy Practices for your provider's and DBHDD's records. I have received a copy of this Notice on the date indicated below.

\_\_\_\_\_  
Signature of Individual or Legally Authorized Person

\_\_\_\_\_  
Date



**NOTICE OF NONDISCRIMINATION:**

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. DBHDD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. To communicate effectively with us, DBHDD provides to people with disabilities free aids and services such as interpreters; and written information in other formats (large print, audio, accessible electronic formats). To communicate effectively with us, DBHDD provides to people whose primary language is not English free language services such as interpreters and information written in other languages. If you need these services, contact Constituent Services at 404-657-5964 or 888-785-6954.

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (404.657.5964 or 888.785.6954)

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उपलब्ध हः।  
(404.657.5964 or 888.785.6954)

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (404.657.5964 or 888.785.6954)

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (404.657.5964 or 888.785.6954)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.  
(404.657.5964 or 888.785.6954) 번으로 전화해 주십시오.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (404.657.5964 or 888.785.6954).

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 (404.657.5964 or 888.785.6954).

ملحوظة: إذا كنت تتحدث (بكر اللغة)، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم  
اتصل (404.657.5964 or 888.785.6954)

ଯୁ ନା: જો તમે જુ રાતી બોલતા હો, તો ી ન: ૃ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન  
કરો  
(404.657.5964 or 888.785.6954).

**ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (404.657.5964 or 888.785.6954).

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (404.657.5964 or 888.785.6954).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما با باشد  
می فراهم (404.657.5964 or 888.785.6954)

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(404.657.5964 or 888.785.6954)

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.  
Rufnummer:  
(404.657.5964 or 888.785.6954)

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。  
(404.657.5964 or 888.785.6954).  
まで、お電話にてご連絡ください。



## **The NOW/COMP program provides the following services to participants:**

**Adult Occupational Therapy** - these services address the occupational therapy needs of the adult participant that result from his or her developmental disabilities.

**Adult Physical Therapy** - these services address the physical therapy needs of the adult participant that result from his or her developmental disabilities.

**Adult Speech and Language Therapy** - these services address the speech and language therapy needs of the adult participants that result from his or her developmental disabilities.

**Adult Nutrition Services** - these services provide evaluation and dietary intervention services that are not otherwise reimbursed through Medicaid State Plan Services. Adult Nutrition Services include nutrition evaluation, education of participant, family, and support staff, and periodic monitoring and dietary intervention to improve nutrition-related health conditions.

**Additional Staffing Services** - these services are provided on behalf of individuals with a high level of functional, medical, or behavioral needs who require direct support or oversight beyond the level provided within traditional service descriptions. This is clinically assessed on a case-by-case basis.

**Behavioral Supports Consultation** - these services are the professional level services that assist the participant with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work, or similar situations.

**Community Access** - these services are designed to assist the participant in acquiring, retaining, or improving self-help, socialization, and adaptive skills required for active participation and independent functioning outside the participant's home or family home.

**Community Guide** - these services are only for participants who opt for participant direction and assist these participants with defining and directing their own services and supports and meeting the responsibilities of participant direction.

**Community Living Support** - these services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to a participant's continued residence in his or her family home.

**Community Residential Alternative** - these services are targeted for people who require intense levels of residential support in small group settings of four or less or in host home/life sharing arrangements and include a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking, toileting, personal grooming and health care, dressing communication, interpersonal relationships, mobility, home management, and use of leisure time. (*Only in COMP WAIVER*)

**Environmental Accessibility Adaptation** - these services consist of physical adaptations to the participants of family's home which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home.

**Financial Support Services** - these services are provided to assure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended,





**Individual Goods and Services** - these services are purchased from the participant-directed budget and cover services that include improving and maintaining the participant's opportunities for full membership in the community. (*PARTICIPANT DIRECTION ONLY*)

**Interpreter Services** - provide sign language interpretation support services that are not otherwise reimbursed through Medicaid State Plan Services. Interpreter services is intended to facilitate communication to aid in the development of ISPs through informed assessment and full participation in planning by the individual and treatment team members.

**Natural Support Training** - these services provide training and education to individuals who provide unpaid support, training, companionship, or supervision to participants.

**Nursing Services** - Clinical nursing services are indicated when the individual has a clinical diagnosis which requires ongoing complex assessment and intervention for the purpose of health restoration or prevention of further deterioration of the health of the individual.

**Prevocational Services** - these services prepare a participant for paid or unpaid employment and include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

**Respite** - these services provide brief periods of support or relief for caregivers or individuals with disabilities and include maintenance respite for planned or scheduled relief or emergency/crisis respite for a brief period of support for a participant experiencing a crisis (usually behavioral) or due to a family emergency.

**Specialized Medical Equipment** - this equipment consists of devices, controls or appliances specified in the Individual Service plan, which enable participants to increase their abilities to perform activities of daily living and to interact more independently with their environment.

**Specialized Medical Supplies** - these supplies consist of food supplements, special clothing, diapers, bed wetting protective chunks, and other authorized supplies that are specified in the Individual Service Plan.

**Support Coordination** - these services are a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services with the objective of protecting the health and safety of participants while ensuring access to needed waiver and other services.

**Supported Employment** - these services are only supports that enable participants, for who competitive employment at or above the minimum wage, is unlikely absent the provision of supports, and who, because of their disabilities, need supports to work in a regular work setting.

**Transportation** - these services enable participants to gain access to waiver and other community services, activities, resources, and organizations typically utilized by the general population but do not include transportation available through Medicaid non-emergency transportation or as an element of another waiver service; and

**Vehicle Adaptation** - these services include adaptations to the participant's or family's vehicle approved in the Individual Service Plan, such as a hydraulic lift, ramps, special seats, and other modifications to allow for access into and out of the vehicle as well as safety while moving,

# FACT SHEET

## New Options Waiver Program (NOW) and Comprehensive Supports Waiver Program (COMP)

### Overview

The New Options Waiver (NOW) and the Comprehensive Supports Waiver Program (COMP) offer home- and community-based services for people with intellectual disabilities (ID) or developmental disabilities (DD). The Department of Community Health (DCH) administers Medicaid which delegates the day-to-day operation of the NOW/COMP Programs to the Department of Behavioral Health and Developmental Disabilities (DBHDD), Division of Developmental Disabilities. DCH maintains administration over the NOW/COMP Program and oversees DBHDD's performance of operational functions. The DBHDD Central Office performs statewide waiver operational and daily administrative functions. The six DBHDD regional offices perform NOW/COMP waiver functions at the regional level, including intake and evaluation, preauthorization of NOW/COMP waiver services, utilization management, crisis resolution, quality management, and intervention in cases of service delivery problems or concerns. Individuals access the NOW/COMP Program through the DBHDD regional offices or the internet. The NOW/COMP waiver serves individuals with intellectual disabilities or other closely related conditions, such as cerebral palsy, epilepsy, autism or neurological problems. These disabilities require a level of care provided in an intermediate-care facility (ICF) for people diagnosed with I/DD. There are more than 12,000 people with developmental disabilities who are served by the NOW/COMP programs in Georgia.



### **NOW/COMP Waiver Program Services**

- Adult Dental Services
- Adult Nursing Service
- Adult Occupational Therapy Services
- Adult Physical Therapy Services
- Adult Speech and Language Therapy Services
- Additional Staffing Services
- Behavioral Supports Services Level I
- Behavioral Supports Services Level II
- Community Access Services
- Community Guide Services
- Community Living Support Services
- Community Residential Alternative Services (COMP only)
- Environmental Accessibility Adaptation Services
- Financial Support Services
- Individual Directed Goods and Services
- Interpreter Services
- Natural Support Training Services
- Nutrition Services
- Pre-vocational Services
- Respite Services
- Respite Out-of-Home 15-minute Services
- Specialized Medical Equipment Services
- Specialized Medical Supplies Services
- Support Coordination Services
- Intensive Support Coordination Services
- Supported Employment Services
- Transportation Services
- Vehicle Adaptation Services

# FACT SHEET



## Purpose of the NOW Program

The NOW waiver program offers services and supports to individuals to enable them to remain living in their own or family home and participate or live independently in the community.

Goals for participants in the NOW program, which serves individuals with less intensive needs than those in the COMP program, include:

- Avoiding the need for more intensive services. Increasing independence and quality of life of individuals with I/DD.
- Increasing the flexibility of service planning and delivery to meet exact individual needs.
- Providing the opportunity for all participants to elect to direct their services to the extent that they choose.
- Ensuring the health, safety and welfare of NOW participants.

## Purpose of the COMP Program

The COMP waiver program, which serves individuals with more intensive needs, primarily provides residential care for individuals with I/DD. These individuals require comprehensive and intensive services and need out-of-home residential support and supervision or intensive levels of in-home services to remain in the community.

The purpose of the COMP program is to offer comprehensive and extensive waiver services to enable individuals with urgent and intense needs to avoid institutional placement. The COMP program provides the level of services needed by individuals transitioning from institutions to community living.

Goals for participants in the COMP program include:

- Avoiding the need for institutional placement.
- Increasing independence and quality of life of individuals with ID/DD who have intensive or comprehensive support needs.
- Facilitating the transition of institutionalized individuals to community living.
- Offering opportunities statewide for participant direction by waiver participants who have intensive or comprehensive support needs.
- Ensuring the health, safety and welfare of COMP program participants.

# FACT SHEET



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

## Eligibility for Both Programs

Individuals who meet the level of care that would be required in an intermediate-care facility for people with intellectual disabilities (ICF-ID) may be eligible for home- and community-based services as an alternative through Georgia's Medicaid NOW and COMP waiver programs.

To qualify for these waiver programs and be offered the choice of community-based services instead of institutional care, the individual must first meet the criteria for Medicaid payment in an institution and certain other criteria.

Specific qualifications:

- Are categorically eligible Medicaid recipients.
- Have a diagnosis of an intellectual disability and/or a closely related condition.
- Are currently receiving the level of care provided in an ICF-ID that is reimbursable under the State Plan, and for whom home- and community-based services are determined to be an appropriate alternative.
- Are likely to require the level of care provided in an ICF-ID that would be reimbursable under the State Plan in the absence of home- and community-based services that are determined to be an appropriate alternative.

## For More Information

Visit the DCH website at: [www.dch.georgia.gov](http://www.dch.georgia.gov) or visit the DBHDD website at [www.dbhdd.georgia.gov](http://www.dbhdd.georgia.gov).

## Georgia's Aging and Disability Network

**1-866-552-4464**

Option 1: DFCS (Food stamps, TANF, Medicaid and more)

Option 2: **ADRC** ([www.georgiaadrc.com](http://www.georgiaadrc.com) see below for more information)

#1 Developmental Disabilities

#2 Brain and Spinal injuries

#3 Physical Disability

#4 Aging

#5 Alzheimer's and Dementia

Option 3: APS to report Abuse Neglect and Exploitation

Option 4: GACares (for questions about Medicare)

Option 5: Long Term Care Ombudsman (for concerns and information)

Option 7: Senior Legal Hotline



— GEORGIA'S —  
**Aging & Disability**  
R E S O U R C E C O N N E C T I O N

Georgia's Aging and Disability Resource Connection (ADRC) is not a place or a program! It is a coordinated system of partnering organizations that are dedicated to:

- Providing accurate information about publicly and privately financed long-term supports and services.
- Offering a consumer-oriented approach to learning about the availability of services in the home and community.
- Alleviating the need for multiple calls and/or visits to receive services.
- Supporting individuals and family members who are aging or living with a disability.



**Family Support Services will require the Individual be found "Pre-Eligible" for the NOW/COMP Waiver first.**

## **Family Support Services**

Family Support Services is a non-entitlement program which brokers disability specific services based on each individual and family's unique needs. Family Support Services are based on the value that families belong together and individuals are best served in the community setting. These supports meet every day needs that are often critical in avoiding family crises. The goal of Family Support Services is to assist in maintaining a cohesive family unit and to assist the individual to live at home in the community.

## **Eligibility**

Individuals, age 3 and up, living in Georgia that have been diagnosed with a developmental disability who are living at home, with their family, and are not currently receiving a NOW/COMP Waiver, are eligible for Family Support Services.

Eligible diagnoses include, but are not limited to:

- Developmental Disability
- Intellectual Disability
- Autism Spectrum Disorders
- Down Syndrome

## **Services**

Family Support Services brokers services and goods that are individualized to meet your family's needs. A Family Support Coordinator will work with your family to develop an individualized Family Support Service Plan. Some of the services might include:

- Information and referral
- Assistance in identifying needs.
- Advocacy to obtain needed services or benefits.
- Assistance locating and acquiring services such as:
  - Respite Services
  - Family Education
- Special Diets, clothing, and personal care items.
- Other services and supports unique to each family's needs.

## **Apply for Services**

Go to the *Georgia Department of Behavioral Health and Developmental Disabilities* website to fill out an application and agreement. Family Support Services applications are accepted at the local community-based providers. Contact the local community-based provider for more information.

<http://dbhdd.georgia.gov/family-support-services>

Provide supporting documentation of the identified developmental disability. Supporting documentation includes documents that indicate the individual has been diagnosed with a developmental disability, including:

- Psychological Evaluation
- School IEP
- Medical Verification of ID/DD by a Physician
- Social Security Disability

## **NOW/COMP WAIVER APPLICATION**

If you have any questions related to the application  
please contact:

Stacey Lane  
Intake Coordinator  
DBHDD Region 1 Field Office  
1230 Bald Ridge Marina Road Suite 800  
Cumming, GA 30041

Direct Office: 770-781-6914

Main Office: 678-947-2818

Fax: 678-947-2817

[Stacey.Lane@dbhdd.ga.gov](mailto:Stacey.Lane@dbhdd.ga.gov)