Division of Family and Children

Application for Benefits

YOU MUST HAND DELIVER, FAX or MAIL THE COMPLETED APPLICATION TO YOUR LOCAL COUNTY OFFICE.

If you need help reading or completing this document or need help communicating with us, ask us or call (877) 423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).

What Services Do We Offer at the Division of Family and Children Services (DFCS)?

DFCS offers the following services:

Food Assistance

Food Stamps (SNAP) benefits can be used to buy food at any store that has the EBT/*Quest* sign. We will subtract the price of your food purchase from your Food Stamp (SNAP) account.

Division of Family and Children

Application for Benefits

Cash Assistance/Employment Support Services

Temporary Assistance for Needy Families (TANF) provides cash assistance to families with dependent children for a limited time. Parents or caretakers who are included in the grant are required to participate in a work program. Cash Assistance program also provides financial assistance to refugee households who are not eligible for the TANF program.

- **Grandparents Raising Grandchildren (GRG)** will provide the support necessary so that children can be cared for in the homes of their grandparents.

Medical Assistance

Medicaid, for those who are eligible, may help pay medical bills, doctor's visits, and Medicare premiums.

Community Outreach Services

For more information about other DHS services, please visit our website at http://dfcs.georgia.gov or call (877) 423-4746.

Division of Family and Children

Application for Benefits

How Do I Apply for Benefits?

Step 1. Fill out the application.

Read the questions carefully and give accurate information. Sign and date the application.

Step 2. Turn in the application to your local office.

You will need to tear off pages 1-2, 17-20 and keep them for yourself.

Mail, fax, or bring in pages 3-16 of this application to your local Division of Family & Children Services (DFCS) office. You can locate your local office at http://dfcs.georgia.gov/locations .

If you or the person for whom you are applying is eligible for benefits, Food Stamp (SNAP) benefits will be provided from

the date we receive the application with your name, address, and signature on it. TANF benefits will be provided from the date the application is approved.

If you are applying for Food Stamps (SNAP), TANF and/or Medicaid, you can file an application for benefits with only your name, address, and signature. However, it may help us to process your application quicker if you complete the entire form. You may use this form to file a joint application for more than one program or for the Food Stamp (SNAP) program only. Your (SNAP) application will not be denied solely on the basis that your application for another program has been denied. We will make a separate eligibility determination for your Food Stamp (SNAP) application. If you are in an institution and applying for Food Stamps (SNAP) and SSI at the same time, the filing date of your application is the date you are released from the institution.

Step 3. Talk with us.

You may need to complete an interview with a worker. If so, we will give you an appointment. This interview can be completed by phone.

Frequently Asked Questions

How long does it take to get benefits? Food Stamps (SNAP): up to 30 days TANF: up to 45 days

Medicaid: 10 to 60 days

You may be able to get Food Stamps (SNAP) within 7 days if you qualify. See page 6.

How much will I get?

Your income, resources, and family size determine benefit amounts. We will be able to give you specific information once we determine your eligibility.

How will I get my benefits?

For Food Stamps (SNAP), you will get an Electronic Benefit Transfer (EBT) card to access your benefits. For TANF, you will get an EPPIC Debit Master card to access your benefits. For Medicaid, you will receive a Medicaid card for each eligible member.

You may be asked to provide the following information:

- Proof of identity for the applicant if applying for Food Stamps (SNAP) and/or TANF. An identification card (ID) or driver's license (DL) is an acceptable form of verification. Proof of Identity is not required for Medical Assistance applicants.
- Proof of US citizenship/qualified immigrant status for everyone requesting benefits. If you are applying for Emergency Medical Services (EMA) only, you do not have to provide your SSN or information about your immigration status.
- Social Security numbers of everyone requesting assistance.
- Proof of income *for example*, pay stubs, child support payments, and income award letters. Proof of child support payments is not needed for Medical Assistance applicants.
- Proof of expenses like childcare receipts, medical bills, medical transportation costs, rent/mortgage costs, and child support payments. This information is not required for Medical Assistance applicants.

We will first attempt to verify citizenship/immigration status and income information through electronic data sources. Paper verification documents

Division of Family

Application for

are not required to submit an application; however, you may provide the

documents with the application. If we are unable to verify through electronic data sources and you need help getting this information, please tell us.

How do we use the applicant's personal information?

You only have to provide Social Security Numbers (SSN) and citizenship or immigration status for persons who want to apply for benefits. This information will be used to check the income and eligibility verification system (IEVS). We will also match your information against other Federal, state, and local agencies to verify your income and eligibility, to track wage information and participation in work activities. If a household member does not want to give us information about their SSN, citizenship or immigration status, other household members may still receive benefits. If you are applying for emergency medical services only, you do not have to provide your SSN or information about your immigration status.

Can someone else apply for me?

For Food Stamps (SNAP) and Medicaid, you may ask someone to apply for you.

For TANF, anyone can apply but the parent or caretaker must be interviewed.

Division of Family

Application for

(Complete this application and return it to your LOCAL COUNTY DFCS office.)

What Am I Applying For? (Check all that apply)

- **Food Stamps** (**Supplemental Nutrition Assistance Program (SNAP)**

  The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, is a federally funded program that provides monthly benefits to low-income households to help pay for the cost of food. The program also provides nutrition education to families to meet their food and nutritional needs and provides employment and training opportunities to help families gain employment that leads to less dependence on SNAP.

- **Temporary Assistance for Needy Families (TANF)**

  Temporary Assistance for Needy Families (TANF) provides temporary monthly cash payments, single cash payments, or other support services, to strengthen eligible families with children. If you are the child's parent, or the caretaker who would like to be included in the grant, we will require you to participate in a work program.

Division of Family

Application for

- **Grandparents Raising Grandchildren (GRG)**




Application for

Grandparents Raising Grandchildren (GRG) will provide additional cash payments so that children can be cared for in the homes of their grandparents. **Applicants must apply for TANF to be eligible for GRG**.

- **Refugee Cash Assistance**

  The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, and unaccompanied refugee minors.

- **Medicaid**

  Medicaid offers medical coverage to elderly, blind or disabled adults, pregnant women, children, and families. When you apply, we will look at all Medicaid programs and decide which ones you may be eligible to receive.

Please fill out the chart below about the applicant.

First Name	Middle Initial	Last Name
Street Address Where You Live		Apt
City	State	Zip Code

Mailing Address (If different)		
Main Telephone Number	Other	Email Address
Electronic Communication: Yes____or No____(optional)		
What is your Preferred Language?		If an interview is required, will interpreter? Yes__or No

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):

Do you have a disability that will require a Reasonable Modification or Communication Assistance? Yes____No____(If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):

Sign Language interpreter____ ; TTY____ ; Large Print____; Electronic communication (email)____; Braille_____; Video Relay____; Cued Speech Interpreter____; Oral Interpreter____; Tactile Interpreter___; Telephone call reminder of program deadlines____; Telephonic signature (if applicable)____; Face-to- face interview (home visit)_ ; Other:__ _____

Do you need this Reasonable Modification or Communication Assistance one-time or ongoing _? If possible, briefly explain when and how long you need this modification or assistance?

For All Food Stamp (SNAP), TANF, and Medicaid Applicants:

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. I understand and agree that DHS-DFCS, DCH and authorized Federal Agencies may verify the information I give on this application. Information may be obtained from past or present employers. I understand that my information will be used to track wage information and my participation in work activities.

I will report any change in my situation according to Food Stamp (SNAP)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of $3750 or more (before taxes or other amounts are withheld). I will report these winnings within 10 days from the end of the month in which my household receives the winnings. I understand if any information is incorrect, my benefits may be reduced or denied, and I may be subject to criminal prosecution or disqualified from DHS-DFCS programs for knowingly providing incorrect information. I understand that I can

be prosecuted if I provide false information or hide information. I understand that if I fail to tell DHS-DFCS about some of my expenses during my application or renewal process and/or fail to verify them, DHS-DFCS will not budget that expense in calculating the amount of my SNAP benefits.

Signature	**Date**
Witness Signature if signed by "X"	**Date**

Authorized Representative:

Complete this section only if you want a person or an organization to fill out your application, complete your interview, and/or use your EBT card to buy food when you cannot go to the store. Please check for each program type who you want to designate as an authorized representative. Please check which duties you want the person or organization to have. If you are applying for Medicaid, you can choose more than one person or organization to act on your behalf.

Division of Family

Application for

Authorized Representative 1 Program Types: Food Stamps (SNAP) ❑ TANF ❑ Medical Assistance ❑

Authorized Representative 1 Duties: Sign application on applicant's behalf ❑

Complete and submit renewal form ❑ Receive copies of notices and other communication ❑

Act on behalf of applicant in all other matters ❑ Receive a TANF benefit card (EPPIC) ❑

Person Name 1:

_____

Organization Name 1 (if applicable):

_____ Phone:

_____

Address:

_____

Apt: _____

City:

_____

State: _____ Zip: _____

Electronic Communication: Yes ____or No ____(optional) Email

Address (optional) _____

Preferred Language:

_____ Is an

interpreter needed? Yes_____or No_____

Authorized Representative 2 Program Types: Food Stamps (SNAP) ❑ TANF ❑ Medical Assistance ❑

Authorized Representative 2 Duties: Sign application on applicant's behalf ❑

Complete and submit renewal form ❑ Receive copies of notices and other communication ❑

Act on behalf of applicant in all other matters ❑ Receive a TANF benefit card (EPPIC) ❑

Person Name 2:

_____

Organization Name 2 (if applicable): _____

Phone: _____

Address:_____

Apt: _____

City: _____

State: _____ Zip: _____

Electronic Communication: Yes ____or No ____(optional) Email Address (optional) _____

Preferred Language: _____ Is an interpreter needed? Yes_____or No_____

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance for Authorized Representatives (if applicable):

Does the Authorized Representative have a disability that will require a Reasonable Modification or Communication Assistance? Yes _____ No _____ (If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):

Sign Language interpreter____; TTY____; Large Print____; Electronic communication (email)____; Braille_____; Video

Division of Family

Application for

Relay____; Cued Speech Interpreter____; Oral Interpreter____;

Tactile Interpreter____; Telephone call reminder of program deadlines____; Telephonic signature (if applicable) ___; Face-to- face interview (home visit) _____; Other: _

Does the authorized representative need this Reasonable Modification or Communication Assistance one-time___or ongoing____? If possible, briefly explain when and how long you need this modification or assistance?_____

_____

For Office Use Only Date Received:__

Division of Family

Application for

Do I Qualify to Get Food Stamps (SNAP) Faster? (This information is required for Food Stamp (SNAP) applicants only)

Answer these questions about the applicant and all household members to see if you can get Food Stamps (SNAP) within 7 days.

1. Are you or any household member a migrant or seasonal farm worker? ❑ Yes ❑ No If yes, who _____

2. Total **Gross earned income** that will be received for this month: $ _____ Employer Name_____

   Employment Begin Date_____

   Employment End Date _____

   Rate of Pay _____ Hours Worked Weekly_____

   How Often Are You Paid: weekly/bi-weekly/semi-monthly/monthly (circle one)

3. Total **Gross unearned income** that will be received for this month: $_____ Type of Unearned Income_____Amount___
   How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

   Type of Unearned Income_____Amount
   How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

4. Total earned and unearned income for this month: $ _

5. How much money do you and all household members have in cash or in the bank? $ _____

6. What is the monthly amount of your rent, mortgage, property taxes, and/or homeowner's insurance? $ _____

7. What is the total amount of your electric, water, gas, and/or other utilities this month? $ _____

(Exclude past due and late fee amounts in the total)

a. What is your household's primary heating or cooling source?
Mark all that apply

Electric____Gas_____Window or central air conditioner

_____Kerosene oil_____Wood_____

b. Have you received energy assistance in the last 12 months?

c. Yes ▪ No ▪ If yes, amount received $_____

Tell Us about the Applicant and All Household Members

For Medical Assistance applicants: Please include yourself, your spouse, your children (including stepchildren) under 21 who live with you,

your unmarried partner who needs health coverage, anyone you include on your tax return, even if they do not live with you, and anyone else

under 21 who you take care of and lives with you. You do not have to include your unmarried partner who does not need health coverage, your unmarried partner's children, your parents who live with you but file their own tax return (if you are over 21), or other adult relatives who file their own tax return. If you are applying for Emergency Medical Services (EMA) only, you do not have to provide your SSN or information about your immigration status.

Please fill out the chart below about the applicant and all household members. 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. §



Division of Family

Application for

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.

Division of Family

Application for

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 (SNAP) 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.

NAME First Middle Initial Last	Relationship	Is this person applying for benefits? (Y/N)	Does this person need health coverage? (Y/N)	Birth Date Format (--/--/--)	Social Security Number **(Applicants Only)**	Sex (M/F)	Hispanic or Latino? **(Optional)** (Y/N)	Race Code **(Optional)** (See codes Below)	Are you a U.S. citizen, U.S. national, or qualified alien/immigrant? **(Applicants only)** (Y/N)
	SELF								

Division of Family

Application for

	Race Codes (Choose all that apply): **AI -** American Indian or Alaska Native **AS -** Asian **BL –** Black or African American **HP -** Native Hawaiian or Other Pacific Islander **WH -** White By providing Race/Ethnicity information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information and it will not affect your eligibility or benefit level.

Division of Family

Application for

If you or other household applicants are not U.S. Citizens or U.S. Nationals, complete the following chart:

NAME First Middle Initial Last	Immigration document type	Document ID number	Have you lived in the U.S. since 1996? (Y/N)	Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? (Y/N)

Tell Us More about the Applicant and All Household Members

We need more information about the applicant and all household members in order to decide who is eligible for benefits. Please answer only the questions about the benefits you want to receive on the page below.

1. Has anyone received any benefits in another county or state? (For Food Stamps (SNAP) and TANF only)

   ❑ Yes ❑ No

   If yes:

   Who: _____

Where: _____

When: _____

2. Has anyone been convicted of giving false information about where they live and who they are to get multiple FS benefits in more than one area after 8/22/1996? (For Food Stamps (SNAP) only) ❑ Yes ❑ No

If yes:

Who: _____

Where: _____

When: _____

3. Did anyone in your household voluntarily quit a job or voluntarily reduce his/her work hours ❑ Yes ❑ No below 30 hours per week within 30 days of the date of application? (For Food Stamps (SNAP) and TANF only)

If yes, who quit? _____

Why did he/she quit?_____

4. Is anyone pregnant? (This question does not apply to Food Stamps (SNAP) applicants) ❑ Yes ❑ No If yes, what is the estimated due date? _____; and how many babies expected? ____ If no, did anyone in the household deliver or was a pregnancy terminated within the last 12 months? ❑ Yes ❑ No
If yes, what was the delivery/termination date? _____ ; and how many babies were delivered/expected? _____
Name of pregnant woman: _____ Unborn _____ baby's father's name: _____
Father's address: _____

5. For Medicaid applicants, does anyone have any unpaid medical bills for the last 3 months? ❑ Yes ❑ No

6. Is anyone disqualified from the Food Stamp (SNAP) or TANF Program? (Food Stamps (SNAP) and TANF only)

❑ Yes ❑ No

If yes:

a. Who: _____

b. Where: _____

7. Is anyone fleeing to avoid prosecution or jail for a felony? (Food Stamps (SNAP) and TANF Only)

❑ Yes ❑ No If yes, who:

_____

8. Is anyone violating conditions of probation or parole? (For Food Stamps (SNAP) and TANF only) ❑ Yes ❑ No

If yes, who:

_____

9. Does anyone have a felony conviction because of behavior related to the possession, use or distribution of a controlled drug substance (i.e., drug felon) after 8/22/1996 (For Food Stamps (SNAP) and TANF only) or a violent felony (TANF only)? ❑ Yes ❑ No

If yes: _____

Who: _____

When:_____

a. Are you in compliance with the terms of probation related to any sentence received as a result of a drug felony conviction? (Food Stamps (SNAP) and TANF only)

❑Yes ❑ No

b. Are you in compliance with the terms of parole related to any sentence received as a result of a drug felony conviction? (Food Stamps (SNAP) and TANF only)

❑Yes ❑ No

c. Have you successfully completed **all the terms of probation or parole** related to any drug related conviction? (Food Stamps (SNAP) and TANF only)

❑Yes ❑ No

10. Have you or any household member been convicted of trading Food Stamp (SNAP) benefits for drugs after

8/22/1996? (For Food Stamps (SNAP) only)

❑Yes ❑ No

If yes:

Who: _____

When: _____

11. Have you or any household member been convicted of buying or selling Food Stamp (SNAP) benefits over $500 after

8/22/1996? (For Food Stamps (SNAP) Only) ❑ Yes ❑ No

If yes:

Who: _____

When: _____

12. Have you or any household member been convicted of trading Food Stamp (SNAP) benefits for guns, ammunition, or explosives after 8/22/1996? (For Food Stamps (SNAP) Only) ❑ Yes ❑ No

If yes:

Who: _____

When:_____

13. Have you or any member of your household been convicted as an adult of aggravated sexual abuse, murder, sexual exploitation, and other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be substantially similar to such an offense, after 2/7/2014? (For Food Stamps (SNAP) only) ❑ Yes ❑ No

If yes, please complete the section below:

Who: _____

When: _____

a. Are you in compliance with the terms of probation related to any sentence received as a result of a felony conviction? (Food Stamps (SNAP) only) ❑Yes ❑ No

b. Are you in compliance with the terms of parole related to any sentence received as a result of a felony conviction? (Food Stamps (SNAP) only) ❑Yes ❑ No

c. Have you successfully completed **all the terms of probation or parole** related to any felony related conviction? (Food Stamps (SNAP)) ❑Yes ❑ No

14. Have you or any household member received lottery or gambling winnings? ❑ Yes ❑ No

If yes:

Who:_____

When: _____

Amount received: _____

15. Has anyone used TANF funds or the EPPIC Card at the following establishments, liquor stores, casinos, poker rooms, adult entertainment business, bail bonds, night clubs, salons/taverns, bingo halls, racetracks, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons.? (For TANF only) ❑ Yes ❑ No

If yes:

Who: _____

When: _____

16. Is anyone who is applying for benefits, currently receiving alimony? ❑Yes ❑ No

If yes:

Who: _____

Monthly Amount received: _____

Date alimony agreement finalized or last modified:

_____

Tell Us about the Applicant and All Household Members Income

Do you or anyone you are applying for receive any type of income such as: wages, tips, bonuses, self-employment, Social Security/Railroad Retirement, other disability, pensions, unemployment, or any other income? For Food Stamps (SNAP) and TANF, please also list income such as: VA income, child support, money from other people or workers compensation. If yes,

complete the chart below.

Household Member Name with Income	Type of Income	Employer Name /Source of Income	Monthly Amount (Before Deductions)	How Often received (monthly, biweekly, weekly)	Pay Per Hour	Hours per Week	DATE (S) PAID

If self-employed, please list your monthly business expenses amount:

$_____

Tell Us about the Applicant and All Household Members

Resources - For TANF applicants, list all resources for all household members and Medicaid applicants who are Aged (65 or older), Blind or Disabled (permanent impairment that prevents you from working)

Do you or anyone you are applying for own any resources?

( ) Yes ( ) No

If yes, please complete the information below (Check all resources (assets) owned by you, your spouse, your dependents or jointly

owned with someone else. Attach additional pages if necessary).

Checking Accounts ( ) Yes ( ) No Funeral Plans/Prepaid Burial Item ( ) Yes ( ) No

Savings Accounts ( ) Yes ( ) No Burial Plots or Contracts ( ) Yes ( ) No

Government Bonds ( ) Yes ( ) No Stocks and Bonds ( ) Yes ( ) No

Trust Funds ( ) Yes ( ) No Other (IRA, CD, etc.) ( ) Yes ( ) No

Real Property/Homeplace Property? ( ) Yes ( ) No

Have you or your spouse given away any assets for less than its value?

( ) Yes ( ) No

If you answered yes to any of these questions, please describe below.

Household Member Name with Resource	Type of Resource	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.

Do you or your spouse own a vehicle? If so, please describe below.

( ) Yes ( ) No

Household Member Who Owns Vehicle	Vehicle Make	Model	Year	Amount Owed

Do you or your spouse have a life insurance policy? ( ) Yes

( ) No

If **yes**, please complete the following information.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

Tell Us about the Applicant and All Household Members Expenses (Optional for Medicaid applicants)

Do you pay for the care of a dependent child or a disabled adult household member? ( ) Yes ( ) No If yes, complete the chart below.

Person who requires care	Person who pays for care	Reason for care	Provider's Name/Number	Amount paid to Provider	How often paid

Do you pay transportation expenses for a dependent child or disabled adult household member? ( ) Yes ( ) No

Are these expenses included in the dependent care expenses?

( ) Yes ( ) No

If no, please answer this question: **Total miles driven weekly**:

_____

Does anyone in the household pay child support to someone living outside of the home? ( ) Yes ( ) No

If yes, complete the chart below.

Household Member Obligated to Pay	Name of Child for Whom Support is paid	Obligated Amount to Pay	Actual Amount Paid	To Whom is Child Support Paid?

Division of Family

Application for

Tell Us More about the Applicant and All Household Members Expenses (Optional for Medicaid applicants)

Does anyone 60 years of age or older or disabled have medical expenses? ( ) Yes ( ) No If yes, complete the chart below.

Household Member Who Has Expense	Type of Expense (doctor visits, hospital visit, prescriptions, Medicare or health Insurance premiums, glasses)	Amount Owed	Still Owed? Yes/No	Date Paid	Will Insurance Pay? Yes/No

Does anyone 60 years of age or older or disabled have medical expenses for transportation? ( ) Yes ( ) No

If yes, complete chart below.

Purpose of the trip (doctor or hospital visit; pharmacy pick-up)	Total miles driven:	Cost of taxi, bus, parking or lodging:

Division of Family

Application for

Do you or any household member have shelter and utility expenses? ( ) **Yes** ( ) **No** If yes, complete the chart below.

Expense	Amount	How Often?	Who paid?
Rent/Mortgage			
Property Taxes			
Property Insurance			
Electricity			
Gas			
Garbage			
Telephone			
Other			

Do you share monthly household expenses with anyone in the home? ( ) **Yes** ( ) **No**

If yes, who? _____

Comments/Documentation_____

Paid to whom_____Amount paid $____per _____

Landlord's Name _____

Landlord's address: _____

_____

Division of Family

Application for

Does someone else pay any of these household bills for you?

( ) Yes ( ) No If yes, complete the chart below:

Who pays the bill?	What bills are paid?
What amount is paid?	To whom does this person pay the bills?

Please complete the following information if applying for Medicaid.

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? ( ) Yes ( ) No

   If **yes**, who? (list each person who plans to file)_____

2. Will any of the tax filers listed file jointly with a spouse?

   ( ) Yes ( ) No If **yes**, please list spouse's name:

   _____

   _____

3. Will any of the tax filers claim any dependents on their tax return?

() Yes () No If **yes**, please list name(s) of dependents

_____

_____

4. Will anyone be claimed as a dependent on someone else's tax return? () Yes () No If **yes**, please list the name of the tax filer and the dependent: (Filer)

_____

(Dependent)

_____

How is the tax dependent related to the tax filer?

_____

Deductions: Check all that apply and give the amount and how often you pay it.

() Alimony paid $_____ How often? _____

() Student loan interest $_____ How often? _____

() Other deductions $_____ How often? _____

Division of Family

Application for

Type: _____

Other health coverage

1. Does anyone have other health insurance that covers anyone in your household? ( ) Yes ( ) No

If you answered **yes** to question 4 above, please complete the following information and Attachment A:

Name of Policy holder	Health Insurance Company Name, Address and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical)	Name of Persons Covered	Effective Date	Policy Number

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

   ( ) Yes ( ) No If **yes**, you need to complete Attachment

   A. Is this a state employee benefit plan? ( ) Yes ( ) No

3. Have you or anyone listed on this application lost any health coverage in the last 2 months?

a. ❍ Yes If **yes**, why was it lost?

b. ❍ No

4. Was anyone in Foster Care at age 18 applying for Medicaid?

❍ Yes ❍ No

5. Is anyone in your household American or Alaska Native?

❍ Yes ❍ No

If **yes**, complete Attachment B.

If anyone is aged (65 or older), blind or disabled (permanent impairment that prevents you from working), please answer questions. (Optional)

1. Is anyone applying for health coverage blind or disabled?

❍ Yes ❍ No If **yes**, please list name

_____

2. Are you or your spouse currently covered by Medicare?

❍ Yes ❍ No If **yes,** please list name _____

3. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?

   ( ) Yes ( ) No If **yes**, date of SSI application:

4. Are you applying for someone who is now deceased and has unpaid medical bills within the last three (3) months?

   ( ) Yes ( ) No

5. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?

   ( ) Yes ( ) No

6. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?

   ( ) Yes ( ) No

7. Are you applying for Medicaid to help pay for community-based waiver services such as Community Care Services, NOW/COMP, Hospice Care, Independent Care Waiver, or the Deeming Waiver (Katie Beckett)?

   ( ) Yes ( ) No

Food Stamp (SNAP) Program Penalties

You may lose your benefits or be subject to criminal prosecution for knowingly providing false information.

- Do not give false information or hide information to get benefits that your household should not get.
- Do not use Food Stamps (SNAP) or EBT cards that are not yours and do not let someone else use yours.
- Do not use Food Stamp (SNAP) benefits to buy nonfood items such as alcohol or cigarettes or to pay on credit cards.
- Do not trade or sell Food Stamps (SNAP) or EBT cards for illegal items; such as firearms, ammunition, or controlled substance (illegal drugs).

Any household member who breaks <u>any</u> of the Food Stamp (SNAP) rules on purpose can be barred from the Food Stamp (SNAP) Program for one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. She/he may also be subject to prosecution under other applicable Federal and State laws. She/he may also be barred from the



Division of Family

Application for

Food Stamp

(SNAP) Program for an additional 18 months if court ordered.

Any household member who intentionally breaks the rules may not get Food Stamps (SNAP) for one year for the first offense, two years for the second offense, and permanently for the third offense.

If a court of law finds you or any household member guilty of using or receiving Food Stamp (SNAP) benefits in a transaction involving the sale of a controlled substance, you or that household member will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you or any household member guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives, you or that household member will be permanently ineligible to participate in the Food Stamp (SNAP) Program upon the first offense of this violation.

If a court of law finds you or any household member guilty of having trafficked benefits for an aggregate amount of $500 or more, you or that household member will be permanently ineligible to participate in the Food Stamp (SNAP) Program upon the first offense of this violation.

If you or any household member is found to have given a fraudulent statement or representation with respect to identity (who they are) or place of residence (where they live) in order to receive multiple Food Stamp (SNAP) benefits, you or that household member will be ineligible to participate in the Food Stamp (SNAP) Program for a period of 10 years.

TANF Program Penalties

In the TANF Program, an IPV (Intentional Program Violation) is an intentional action by an individual to establish or maintain an assistance unit's (AU's) eligibility, or to increase or prevent a decrease in the AU's benefits, by providing false or misleading information or withholding information.

- Any household member who hides information and does not report changes on time or does not tell the truth will lose TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation. The misuse of the cash assistance funds or TANF DEBIT card to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities "strip clubs", poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, race tracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons is strictly prohibited and will result in a loss of TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation.

- If a court of law finds you or any household member hiding information or you do not report changes on time or do not tell the truth and are convicted, you may not get TANF for 6 months for the first violation, 12 months for the second

violation and permanently for the third violation.

- If a court of law finds you or any household member guilty of giving false information about where you live so you can receive benefits in more than one state, you will be barred for 10 years.

- If a court convicted you of a drug-related charge, controlled substance, or a serious violent felony on or after 1/1/1997, you or that household member will not be eligible and/or permanently disqualified.

Division of Family

Application for

For All Food Stamp (SNAP), TANF, and Medicaid Applicants:

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. I understand and agree that DHS-DFCS, DCH and authorized Federal Agencies may verify the information I give on this application. Information may be obtained from past or present employers. I understand that my information will be used to track wage information and my participation in work activities.

I will report any change in my situation according to Food Stamp (SNAP)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of $3750 or more (before taxes or other amounts are withheld). I will report these winnings within 10 days from the end of the month in which my household receives the winnings. I understand if any information is incorrect, my benefits may be reduced or denied, and I may be subject to criminal prosecution or disqualified from DHS-DFCS programs for knowingly providing incorrect information. I understand that I



Division of Family

Application for

can

be prosecuted if I provide false information or hide information. I understand that if I fail to tell DHS-DFCS about some of my expenses during my application or renewal process and/or fail to verify them, DHS-DFCS will not budget that expense in calculating the amount of my SNAP benefits.

_____ _____

Applicant's Signature Date

_____ _____

Authorized Representative's Signature Date

VOTER REGISTRATION INFORMATION

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

___Yes

___No

___I do not want to answer the Voter Registration question

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.

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, Ste. 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.

A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration application from your caseworker. If you complete a Voter Registration application, submit it to the Georgia Secretary of State's Office following the instructions provided on the Voter Registration application.

(Keep these documents for your information)

What Do the Words Used in this Application Mean?

This chart explains the words we have used in this application.

Applicant	An individual who chooses to apply for or to receive public assistance or benefits.
Assistance Unit (AU)	An assistance unit includes *eligible* individuals who live together and receive public assistance/benefits.
Caretaker	A parent, relative or legal guardian who applies for and receives TANF with children in his or her care.
Disqualified	The action taken to remove an individual from a Food Stamp (SNAP) or TANF case because they did not tell the truth and received benefits that they should not have received.
Electronic Benefit Transfer (EBT)	The system used in Georgia to pay benefits to individuals who are eligible for Food Stamps (SNAP). Individuals receiving assistance are issued an EBT debit card, which is used to access their Food Stamp (SNAP) accounts.
Electronic Communications	You have the option to choose how you would like to receive notifications about your information. If you choose to receive email or text notifications, you will receive a message notifying you that you have a notice in My Notices located in GA Gateway Customer Portal. For Email Communication, you must provide us with your email address and accept the terms and conditions for paperless notices located in GA Gateway Customer Portal after you create an account. Please visit the GA Gateway Customer Portal Website at www.gateway.ga.gov to update your notification settings. For Texting Communication, you must provide us with your phone number. Standard message and data rates may apply. This may vary by carriers, please check with your provider.
EPPICard debit MasterCard	The State of Georgia has implemented a convenient "electronic" payment option for the TANF recipients called the EPPICard debit MasterCard. Under this payment option, money is deposited in the recipient's account on the first calendar day of the month. If the first falls on a weekend or holiday, benefits are made available on the last business day of the prior month. The recipient has immediate access to his or her funds because the funds are electronically loaded to the debit MasterCard.
Grantee Relative	A parent, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children.
Gross Income	A person's total income before taking taxes or other deductions into account.
Household Members	Individuals who live in your home. For Food Stamps (SNAP), individuals who live together and purchase and prepare their meals together.
Income	Payments such as wages, salaries, commissions, bonuses, worker's compensation, disability, pension, retirement benefits, interest, child support or any other form of money received.

Middle Class Tax Relief Act of 2012	This Act prohibits the use of cash assistance funds or TANF Debit Cards to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities, poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, racetracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons. The use of cash assistance funds or the TANF Debit Card at these businesses will constitute an intentional program violation (fraud) on the part of the recipient.
Migrant Farm Workers	Individuals who are seasonal farm workers and who move from one home base to another to work or look for farm work.
Non-applicant	An Individual who does NOT apply for or receive public assistance/benefits; non-applicants are not required to provide an SSN, citizenship, or immigration status.

Qualified Alien/Immigrant	A *qualified alien/immigrant* is a person who is legally residing in the U.S. who falls within one of the following categories: • a person *lawfully admitted for permanent residence* (LPR) under the Immigration and Nationality Act (INA); • *Amerasian* immigrant under section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988; • A person who is *granted asylum* under section 208 of the INA; • *Refugees*, admitted under section 207 of the INA; • A person *paroled* into the US under section 212(d)(5) of the INA for at least one year; • A person whose *deportation* is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or section 241(b)(3) of the INA, as amended; • A person who is *granted conditional entry* under section 203(a)(7) of the INA as in effect prior to April 1, 1980; • *Cuban or Haitian* immigrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980; • *Victims of human trafficking* under section 107(b)(1) of the Trafficking Victims Protection Act of 2000; • *Battered immigrants* who meet the conditions set forth in section 431 (c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended; • *Afghan or Iraqi* immigrants granted special immigrant status under section 101(a)(27) of the INA (subject to specified conditions*);* • *American Indians* born in Canada living in the U.S. under section 289 of the INA or non-citizens of federally recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and; • *Hmong or Highland Laotian tribal members* that rendered assistance to U.S. personnel by taking part in military or rescue operation during Vietnam Era (8/05/1964 – 5/07/1975). For Medical Assistance Applications only, Compact of Free Association (COFA) are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.
Resources	Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance.
Seasonal Farm Workers	Individuals who work at certain times of the year planting, picking, or packing produce. They are hired on a temporary basis when a job requires more workers than the farm employs on a regular basis.
Trafficking in the Food Stamp/SNAP Program	*Trafficking* SNAP benefits means: (1) Buying, selling, stealing, or otherwise exchanging SNAP benefits issued and accessed via EBT cards, card numbers and PIN numbers or by manual voucher and signature, for CASH or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; (2) The exchange of firearms, ammunition, explosives, or controlled substances; (3) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount; (4) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; (5) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food; (6) Attempting to buy, sell, steal, or otherwise affect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone.

For All Medicaid Applicants:

To report suspected Medicaid fraud on recipients or providers, call the Georgia Department of Community Health-Office of Inspector General at

(local) (404) 463-7590 or (toll free) (800) 533-0686; by email at oiganonymous@dch.ga.gov; by mail at Department of Community Health, OIG PI Section, 2 Peachtree Street NW, 5th Floor, Atlanta, GA 30303; or visit https://dch.georgia.gov/report-medicaidpeachcare-kids-fraud.

Notice of ADA/Section 504 Rights

Help for People with Disabilities

The Georgia Department of Human Services and the Georgia Department of Community Health ("the Departments") are required by federal law* to provide persons with disabilities an equal opportunity to participate in and qualify for the Departments' programs, services, or activities. This includes programs such as SNAP, TANF and Medical Assistance.

The Departments provide reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities communication assistance, such as sign language interpreters. Our help is free. The Departments are not required to make any modification that would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens.

How to Request a Reasonable Modification or Communication Assistance

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at (404) 657-3433 or DCH at (678) 248- 7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dfcs.georgia.gov/adasection-504-and-civil-rights, or you may obtain the DCH ADA Reasonable Modification Request Form at the DCH Katie Becket (KB) Team office or online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, but you do not have to use a form.

How to File a Complaint

You have the right to make a complaint if the Departments have discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a

reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, Ste. 19-454, Atlanta, GA 30303, (404) 657-3735. For DCH, contact the KB TEAM ADA/Section 504 Coordinator at 2211 Beaver Ruin Road, Ste. 150, Norcross, GA 30071, or PO Box 172, Norcross, GA 30091, (678) 248-7449.

You can ask your case worker for a copy of the DFCS Civil Rights, ADA/Section 504 complaint form. The complaint form is also available at https://dfcs.georgia.gov/adasection-504-and-civil-rights. If you need help making a discrimination complaint, you may contact the DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) is within the “USDA-HHS Joint Nondiscrimination Statement” included within.

**Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.*

Under the **Department of Human Services (DHS)** policy, you may also file other discrimination complaints by contacting your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, Ste. 19-454, Atlanta, GA 30303, (404) 657- 3735. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, Ste. 29-103, Atlanta, GA 30303, or call (404) 657-5244.

Under the **Department of Community Health (DCH)** policy, the Medical Assistance programs cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or religion.

Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at

https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue SW
   Washington, D.C. 20250-9410

2. fax: (202) 690-7442; or

3. email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue SW, Washington, D.C. 20201, or call (800) 368-1019 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.