We will consider this application without regard to race, color, sex, age, disability, religion, or national origin.

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept.

☐ Pregnant Woman ☐ Women's Health

☐ Child under 19 ☐ Parent Caretaker

Check block(s) that apply to you: ☐ Chafee Independence Program Medicaid

Were you in foster care on your 18th birthday? ☐ Yes ☐ No in which state? _____

PLEASE NOTE: A face-to-face interview is not required for Medicaid applications. Please answer all questions as completely and accurately as possible. **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).**

Your Name: (Please Print) FIRST M.I. Last Maiden (if applicable)		Today's Date:	
Mailing Address:	City:	State:	Zip Code:
Residence Address (if different from Mailing Address):	Phone Number(s):	E-mail Address:	
Electronic Communication: Yes___ or No___ (optional)*	What is your Preferred Language? If an interview is required, will you need an interpreter? Yes ___ 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?

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE

You can give a trusted person or organization permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf.

This person or organization is called an "authorized representative." If you ever need to change your authorized representative, contact Division of Family and Children Services (DFCS) at (877) 423-4746. If you are a legally appointed representative for someone on this application, submit proof with the application.

Person Name: (Please Print) FIRST Last		Organization Name (if applicable):	
Address:	City:	State:	Zip Code:
What is your Preferred Language? If an interview is required, will you need an interpreter? Yes ___ No ___	Phone Number(s):	Electronic Communication: Yes__ or No_ (optional)* E-mail address:	

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance <u>for Authorized Representatives</u> (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 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?

*****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. Please list all persons living with you for whom you want or DON'T want Medicaid, including yourself. You do not have to provide an SSN or immigration status information for any person who is not asking for Medicaid. If provided, we will use the SSN for computer matches with other agencies and it may help us process your child's application. We will NOT share your information with the Department of Homeland Security (formerly the INS).

First Name	MI	Last Name	Suffix (Jr.)	Race	Sex M/F	Date of Birth	Relationship to You	Does this person need health coverage? (Y/N)	Social Security Number	Is this person a U.S. Citizen, U.S. National or qualified alien/immigrant? (Y/N)	Does the Father of this child live in your home? (Y/N)	Does the Mother of this child live in your home? (Y/N)

If you or other household members 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, your spouse or parent a veteran or an active-duty member of the U.S. military? (Y/N)

Are you pregnant? ☐ Yes ☐ No; If yes what is the estimated due date? _____; and how many babies are expected? _____; If no, did you deliver or was a pregnancy terminated the last 12 months? ☐Y es ☐N

If yes, what was the delivery/termination date? _____; and how many babies were delivered/expected? _____; Are you able to have a baby? ☐ Yes ☐No; Have you ever delivered a baby weighing

less than 2500 grams (5 pounds, 8 ounces)? ☐Yes ☐No; Have you delivered a baby weighing less than 1500 grams (3 pounds, 5 ounces) on or after January 1, 2011? ☐Yes ☐No; Do you have any unpaid medical

bills from the past three months? ☐Yes ☐No; If yes, which months?
; Are you currently covered by other Health Insurance? ☐Yes ☐No; Are you currently

on Medicaid? ☐Yes ☐No; If yes, list Insurance Company and policy number:
; Does anyone in the household have any private health insurance? ☐Yes ☐No Have you or anyone in your household been diagnosed with Breast or Cervical Cancer? ☐Yes ☐No If yes, have you received Women's Health Medicaid previously? ☐Yes ☐No

INCOME/SELF-EMPLOYMENT, TAX FILER INFORMATION, DEDUCTIONS and DEPENDENT CARE

List all income received by persons on page 1 of this application. Be sure to show the amount before deductions. Attach an extra sheet if necessary. We will decide, based on the type of Medicaid, whose income must be counted and whose may be excluded.

Income	**Gross Amount per Paycheck** (amount before deductions)	**How Often?** (weekly, every 2-weeks, monthly, etc.?)	**Name of Person Receiving**	**Tax Filer Information**
Wages/Earnings				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) _____ _____
Current Employer:				
Wages/Earnings				2. Will any of the tax filers listed file jointly with a spouse? ○Yes ○No If **YES**, please list spouse's name: _____ _____ _____
Current Employer:				
Social Security Income/SSI				
Worker's Compensation				3. Will any of the filers claim any dependents on their tax return? ○Yes ○No If **YES**, please list the names of the dependents: _____ _____ _____
Pensions or Retirement Benefits				
Child Support/ Contributions				
Unemployment Benefits				4. Will anyone be claimed as a tax dependent on someone else's return? ○Yes ○No If **YES**, please list the name of the tax filer and the tax dependents: _____ _____ _____ _____ How is the tax dependent related to the tax filer? _____ _____
Other Income, please specify:				

If you or anyone on page 1 on this application is self-employed, complete the chart below.

Type of self-employment	Name of person self-employed	Monthly gross amount	Monthly business expenses amount

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

□ Alimony paid Amount: _____ How often? _____ ❍ Student loan interest Amount: ___ How often? _____

□ Other deductions Type: _____ Amount: _____ How often? _____

Do you pay for dependent care (daycare for a child or care for an adult who cannot care for himself/herself) so that someone in your household can work?

Name of Parent who works	Name of child or adult cared for	Name of care provider	Amount of Payment	How Often? (weekly, 2-weeks, monthly, etc.)

If you are applying for Medicaid for children and one or both of their parents are not in the home, please provide the following information:

Child's Name	**Absent Parent's Name (Mother/Father)**	**Do they have Medical Coverage on the Child? Yes/No**	**If Yes to Medical Coverage, please list name of insurance company & group number**

I understand that this information may need to be verified to determine eligibility. I understand wage and salary information supplied by the Georgia Department of Labor may be obtained to verify and determine eligibility for Medicaid. I agree to assign to the state all rights to medical support and third-party support payments (hospital and medical benefits). I agree to give the State the right to require an absent parent provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services in obtaining this support. If I do **not** cooperate, I understand I may lose my Medicaid benefits, and only my children will receive benefits unless good cause is established. I understand that I must report changes in my income and circumstances within ten (10) days of becoming aware of the change.

☐ I declare under penalty of perjury that I am a U.S. Citizen and/or lawfully present in the United States. If I am a parent or legal guardian, I declare that the applicant(s) is a U.S. Citizen and/or lawfully present in the United States.

☐☐I declare to the best of my knowledge and belief that the person(s) for whom I am applying for Medicaid is/are U.S. citizen(s) or are lawfully present in the United States. I further certify under penalty of perjury that all of the information provided on this application is true and correct to the best of my knowledge.

Applicant Signature:_____ Date: _____

Authorized Representative 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.

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 Health and Human Services (HHS) is within the "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, or religion.

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. Additionally, program information may be made available in languages other than English.

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.

Any person or representative for a Katie Beckett applicant or participant may file a verbal or written complaint alleging unlawful discrimination by contacting the DCH Civil Rights

Coordinator, Policy, Compliance and Operations Office, Medical Assistance Plans Division, DCH at (local) 404-967-0401, or via email to DCH.CivilRights@dch.ga.gov, or via U.S. mail to:

The Georgia Department of Community Health
DCH Civil Rights Coordinator
Policy, Compliance and Operations Office
Medical Assistance Plans Division
2 Peachtree Street, NW
37th Floor
Atlanta, GA 30303