

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.

Check block(s) that apply to you:

- Pregnant Woman
- Women's Health
- Child under 19
- Parent Caretaker
- Katie Beckett
- Chafee Independence Program Medicaid
- Planning for Health Babies (P4HB)

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		
<p><b>Americans with Disabilities Act: Request for Reasonable Modification &amp; Communication Assistance (if applicable):</b>  <b>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):</b>            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: ___  <b>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?</b></p>					

**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:	
Authorized Representative Duties: Sign application on applicant's behalf <input type="checkbox"/> Complete and submit renewal form <input type="checkbox"/> Receive copies of notices and other communication <input type="checkbox"/> Act on behalf of applicant in all other matters <input type="checkbox"/>				
<p><b>Americans with Disabilities Act: Request for Reasonable Modification &amp; Communication Assistance for Authorized Representatives (if applicable):</b>  <b>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):</b>            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: ___  <b>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?</b></p>				

\*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](http://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 a Naturalized Citizen, or a qualified alien/immigrant complete the following chart.

First	Name Middle Initial	Last	Immigration document type	Alien/Certificate 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?  Yes  No; 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? <input type="radio"/> Yes <input type="radio"/> No If YES, who? (List each person who plans to file) _____ 2. Will any of the tax filers listed file jointly with a spouse? <input type="radio"/> Yes <input type="radio"/> No If YES, please list spouse's name: _____ 3. Will any of the filers claim any dependents on their tax return? <input type="radio"/> Yes <input type="radio"/> No If YES, please list the names of the dependents: _____ 4. Will anyone be claimed as a tax dependent on someone else's return? <input type="radio"/> Yes <input type="radio"/> 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? _____
Current Employer:				
Wages/Earnings				
Current Employer:				
Social Security Income/SSI				
Worker's Compensation				
Pensions or Retirement Benefits				
Child Support/Contributions				
Unemployment Benefits				
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? \_\_\_\_\_  
 Health Insurance Premiums, 401K, and Other Pre-Tax Deductions \$ \_\_\_\_\_ 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?	If Yes to Medical Coverage, please list name of insurance company & group number

**EXPRESS LANE ELIGIBILITY:**

Express Lane Eligibility (ELE) is an automatic process to enroll or renew eligible children under the age of 19 who are receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) into the Medical Assistance program.

If you are receiving SNAP or TANF, the Division of Family and Children Services (DFCS) will use the household size, residency, and income information from SNAP or TANF, but DFCS will verify citizenship or immigration status using Medical Assistance rules to make an ELE determination to enroll or renew the children in Medicaid or PeachCare for Kids®. If your children are eligible for PeachCare for Kids®, they may be subject to a premium. DFCS will send you a determination notice, let you make any changes and allow you to opt out at any time.

If you would like your children to be evaluated for Medical Assistance using the ELE process, please select yes or no below.

Yes  No

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.

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

- I declare under penalty of perjury that I am a U.S. Citizen, U.S. National or qualified alien in the United States. If I am a parent or legal guardian, I declare that the applicant(s) is a U.S. Citizen, U.S. National or qualified alien 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), U.S. National(s) or qualified alien 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.**

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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](mailto:oiganonymous@dch.ga.gov); by mail at Department of Community Health, OIG PI Section, 2 Peachtree Street NW, 5<sup>th</sup> 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 (877) 423-4746 or the DCH Katie Beckett (KB) Team 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 from the KB Team 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, 29<sup>th</sup> Floor, Atlanta, GA 30303, (877) 423-4746. For DCH, contact the KB Team ADA/Section 504 Coordinator at 2211 Beaver Run Road, Ste. 150, Norcross, GA 30071, or PO Box 172, Norcross, GA 30091, (678) 248-7449. The DCH email is: [dch.adarequests@dch.ga.gov](mailto:dch.adarequests@dch.ga.gov).

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. The email for DCH Civil Rights complaints is: [dch.civilrights@dch.ga.gov](mailto:dch.civilrights@dch.ga.gov). The link for the DCH Civil Rights process and complaint form is located at <https://dch.georgia.gov/adasection-504-and-civil-rights>.

*\*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 DHS, you may file discrimination complaints by contacting your local DFCS office or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, 29<sup>th</sup> Floor, Atlanta, GA 30303, (877) 423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, 29<sup>th</sup> Floor, Atlanta, GA 30303, (877) 423-4746 (voice).