GEORGIADEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form
Approved OMB
No. 0938-1191

Application for Health Coverage &

Help Paying Costs

Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premiums for healthcoverage.
- Free or low-cost insurance from **Medical Assistance**.
- **You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).**

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit **HealthCare.gov**.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.

- If someone is helping you fill out this application, you may need to complete Attachment C.
-

Apply faster online

Apply faster online at **gateway.ga.gov.**

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance

- Information about any job-related health insurance available to your family

What happens next?

Send your complete, signed application to the address on page 8. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit gateway.ga.gov or call **1-877-423-4746**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** gateway.ga.gov
- **Phone:** Call our Help Center at **1-877-423-4746.**
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-877-423-4746** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-877-423-4746.**

NEED HELP WITH YOUR APPLICATION? Visit gateway.ga.gov or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

Form 94a (Rev. 1/22)

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number ( ) –	15. Other phone num ( ) –		

16. Do you want to get information about this application by email? Yes No Email address:

17. What is your preferred spoken or written language (if not English)?_____If an interview is required, will you need an interpreter? Yes_____No__

*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.

STEP Tell us about your

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) - - _ _ _ _

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-255-0135.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: How are you related to the tax filer?

7. 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 within the last 12 months? ☐ Yes ☐ No
If yes, what was the delivery/termination date? / / ; and how many babies were delivered/expected? _____

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? Yes. Fill in your document type and ID number below.
☐
a. Immigration document type
b. Document ID number
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time ☐ Yes ☐ No | 15. Were you in foster care at age 18 or ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

17. **Race (OPTIONAL—check all that apply.)**
☐ White ☐ African American ☐ Americ ☐ an Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Black or

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Filipino
Japanese
Korean

Vietnamese Other
Asian Native Hawaiian

G
u
a
m
a
n
i

☐ an or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other

STEP 2: PERSON (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name and

19. Employer phone
( )

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and

23. Employer phone number
( )

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _

25. Average hours worked each WEEK

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ Start working more hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _

28. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI). ☐ None

☐ Unemployment $ How often?

☐ Pensions $ How often?

☐ Social Security $ How often?

☐ Retirement accounts $ How often?

☐ Alimony received $ How often?

☐ Net farming/fishing $ How often?

☐ Net rental/royalty $ How often?

☐ Other income $ How often?

Type: _

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

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ _ How often?

☐ Student loan interest $ _ How often?

☐ Other deductions $ _ How often?

Type: _

30. **YEARLY INCOME:** **Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the** 

Your total income **this year**	Your total income **next** year (if you think it will be different)

THANKS! This is all we need to know about you.

STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) - -
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address:

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse:

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents:

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer:

How is PERSON 2 related to the tax filer?

8. Is PERSON 2 pregnant? ☐ Yes ☐ No If yes, what is the estimated due date / / ; and how many babies are expected? _____

If no, did PERSON 2 deliver or was a pregnancy terminated for PERSON 2 within the last 12 months? ☐ Yes ☐ No
If yes, what was the delivery/termination date for PERSON 2? / / ; and how many babies were delivered/expected? _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page
Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ☐ Yes. Fill in their document type and ID number below.

a. Document type

b. Document ID number

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is under the age of 19.

16. Did PERSON 2 have health insurance and lose it within the past 2 months? ☐ Yes ☐ No

a. **If yes**, end date:

b. Reason the insurance ended:

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

19. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other

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Now, tell us about any income from PERSON 2 on the

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and

21. Employer phone number ( )

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐

$.

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and

25. Employer phone number ( )

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$.

27. Average hours worked each WEEK

28. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ Start working more hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$.

30. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ How often?

☐ Pensions $ How often?

☐ Social Security $ How often?

☐ Retirement accounts $ How often?

☐ Alimony received $ How often?

☐ Net farming/fishing $ How often?

☐ Net rental/royalty $ How often?

☐ Other income $ How often?

Type:

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

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $. How often?

☐ Student loan interest $. How often?

☐ Other deductions $. How often?

Type:

32. **YEARLY INCOME:** **Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)

THANKS! This is all we need to know about PERSON 2.

NEED HELP WITH YOUR APPLICATION? Visit gateway.ga.gov or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you.

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

STEP American Indian or Alaska Native (AI/AN) family

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Attachment B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medical Assistance_____

☐ Medicare

☐ TRICARE (Don't check if you have direct care or Line

☐ of Duty) VA Health Care Programs _____

☐ Peace Corps

☐ Employer insurance:

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance:

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

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. If yes,** you'll need to complete and include Attachment A.

☐ **NO. If no, continue to Step 5.**

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?

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STEP Read & sign this

- I'm signing this application under penalty of perjury which means I've

  provided true answers to all the questions on this

  form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.

- I know that I must report any changes within 10 calendar days of the date of which the change occurs. I can visit **gateway. ga.gov** or call **1-877-423-4746** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.

- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

  _____ is

  incarcerated. (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, Department of Labor (DOL), TALX (work number), the Department of Homeland Security and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health

coverage in future years, I agree to allow the Health Insurance Agencies, DFCS and the FFM to use income data, including information from tax returns. The Health Insurance Agencies, DFCS and the FFM will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medical Assistance

- I am giving to the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medical Assistance agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Agencies, DFCS and the FFM has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Agencies, DFCS or the FFM that I think the action is

wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Division of Family & Children Services (DFCS) at **1-877-423- 4746**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Attachment C.

Signatur	Date

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 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?

_____

_____

STEP 6 Mail completed application.

Mail your signed application to the address below:

Division of Family and

Children Services Customer

Contact Center

P.O. Box 4190

Albany,

GA

31706

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