ATTACHMENT

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form
Approved OMB

Assistance with Completing this Application

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 1-877-423-4746. If you're a legally appointed representative for someone on this application, submit proof with the application. If you need to assign more than one authorized representative, please complete another Attachment C.

1. Person Name (First name, Middle name, Last name)

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code

7. Phone number
( ) –

8. Organization name

9. ID number (if applicable)

10. Authorized Representative 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 ❑

11. Preferred Language

12. Is an interpreter needed? Yes ❑ No ❑

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

13. Your signature

14. Date (mm/dd/yyyy)

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):
Please let us know if due to disability you require any reasonable modifications or communication assistance. Reasonable modifications allow an individual with a disability an equal opportunity to participate in all public assistance programs for which an individual may be otherwise eligible to receive.

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 more information and additional ways to request a reasonable modification or communication assistance please see the attached Notice of ADA/Section 504 on page 9 of the full Medical Assistance application.

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

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

3. Organization name

4. ID number (if applicable)

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**.