Division of Family and Children Services

Georgia Senior Supplemental Nutrition Assistance Program (SNAP) Application

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).

This application is used for individuals applying for the Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program. The Georgia Senior SNAP program is an elderly simplified application project designed to make it easier for seniors to receive SNAP benefits. You can file this 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. If you or the person for whom you are applying is eligible for benefits, SNAP benefits will be provided from the date we receive the application with your name, address, and signature on it.

To be eligible for Senior SNAP benefits, everyone in the household must be:

- 60 years of age or older;
- purchasing and preparing their meals together;
- receiving no earnings from work; AND
- receiving fixed income such as SSA, SSI, Federal or State Retirement, Railroad Retirement, VA, and disability income

You may file this application by completing your name and address, and by signing this form. If you are living in an institution and applying for SNAP and SSI at the same time, the filing date of your application is the date you are released from the institution.

Tell us who you are and where you live. We must be able to reach you by telephone.

First Name	*Middle Initial*	*Last Name*	*Suffix*
Street Address Where You Live			*Apt*
City		*State*	*Zip Code*
Are you homeless? ____ Yes ____ No			
Mailing Address (if different)			
City		*State*	*Zip Code*
Home Telephone Number	*Other Contact Number*		*E-Mail address (optional)*
What is your Preferred Language?			
Electronic Communication: Yes____ or No____ (Optional)			*If an interview is required, will you need an interpreter? Yes____ or No____*
For Office Use Only		Date Received By The County	

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? _____

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Can I Choose Someone to Apply for SNAP for me?

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 the box next to SNAP if you want to designate someone as your authorized representative. Please check which duties you want the person or organization to have.

Authorized Representative Program Types: SNAP ❑
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 ❑

Person Name 1: _____

Organization Name 1 (if applicable): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Email: Yes ___ No ___ (optional) Texting: Yes ___ 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 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?

Do I Qualify to Get SNAP Benefits Faster?

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

Did anyone in your household get money this month? ❍ Yes ❍ No If yes, how much?_____

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

$_____ How much do you and all household members pay for rent or mortgage and all utilities (electric, gas, water, etc.?) $ _____

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Tell us about the applicant and all household members. List yourself (or the person above shown on the first line).

NAME First	Middle Initial	Last	Relation-ship to You	Social Security Number (SSN) **(See statement below)**	Date of Birth	Sex (M/F)	Age	*** Optional		Are you a U.S citizen, qualified alien or in a satisfactory immigration status? (Y/N)
								Hispanic Yes /No	Race (See below)	
			SELF							

*** **Penalty Warning:** Individuals who are applying for SNAP must provide or apply for an SSN as required by the Food and Nutrition Act of 2008. We will verify and use your SSN for Federal and State data matches, including but not limited to, Social Security, VA, GA Department of Labor, program disqualifications, and for collection of fraud debts. We will also match your information with other Federal, state, and local agencies to verify your income and eligibility. Collateral contacts will be used to verify information when discrepancies are found. If immigration status information has been submitted on your application, this information may be subject to verification through the United States Citizenship and Immigration Service (USCIS) and will require the submission of certain information from this application to USCIS.

*** **Optional:** We collect data on race color, and national origin to ensure we are in compliance with Federal civil rights laws. By providing this 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. **Choose one or more race codes**: **AL**-American Indian/Alaska Native; **AS**-Asian; **BL**-Black; or African American; **HP**-Hawaiian or other Pacific Islander; **WH**-White.

Tell us more about the applicant and all household members

1) Has anyone been convicted of a drug-related felony that was committed after 8/22/96? Yes ( ) No ( )
   If yes, name of person: _____
   a) Are you in compliance with the terms of probation related to any sentence received as a result of a drug felony conviction? ( ) 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? ( ) Yes ( ) No
   c) Have you successfully completed <u>all</u> the terms of probation or parole related to any drug related conviction? ( ) Yes ( ) No
2) Is anyone in your household currently serving a SNAP disqualification due to fraud? Yes ( ) No ( )
   If yes, name of person: _____
3) Has anyone been convicted of giving false information about where they live and who they are to get multiple SNAP benefits in more than one area after 8/22/96? Yes ( ) No ( )
   If yes, name of person:_____when:_____where: _____
4) Is anyone trying to avoid prosecution or jail for a felony? Yes ( ) No ( )
   If yes, who: _____
5) Is anyone violating the conditions of probation or parole? Yes ( ) No ( )
   If yes, who: _____
6) Have you or any household member been convicted of trading SNAP benefits for drugs after 8/22/96?
   Yes ( ) No ( )

7) Have you or any household member been convicted of buying or selling SNAP benefits over $500 after 8/22/96? Yes ( ) No ( )

8) Have you or any household member been convicted of trading SNAP benefits for guns, ammunition or explosives after 8/22/96? Yes ( ) No ( )

9) 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 2/7/14?
❑ 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? ❑Yes ❑ No

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

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

10) Have you or any household member received lottery or gambling winnings? Yes ( ) No ( )
If yes:
Who: _____
When: _____
Amount received: _____

Tell us about the income your household receives

Does anyone in your household receive money from social security, SSI, VA, retirement, or any other income?

Yes ( ) No ( ) **If yes, complete the chart below.**

Name	Source	Gross Monthly Amount (before taxes, deductions and Medicare

Tell us about your shelter and utility expenses

	YES	NO	If YES, list monthly/yearly amount
Does your household pay mortgage?			
Does your household pay rent?			
Does your household pay property taxes on the home?			
Does your household pay homeowner's insurance?			
Does your household pay for heating or cooling costs?			

If your household does not pay heating or cooling costs, do you pay other utilities?			**If YES, list the utility costs you pay and the amount you pay below.**

Tell us about your medical expenses

Does your household pay out-of-pocket medical expenses over $35 per month? Yes ( ) No ( )

Do you pay a Medicare Premium? Yes ( ) No ( )

If yes, complete the chart below. We will need proof of your medical expenses. You may be potentially eligible to receive more benefits.

Person Who Has The Bill	Type of Expense (Doctor, Hospital, Prescriptions, Medicare Premium, transportation)	Amount Owed

Do you or someone in your household pay legally obligated child support to someone living outside of your home? Yes ☐ No ☐ If yes, who and how much per month? _____

For more information about Community Outreach Services, please call (877) 423-4746 or visit our website at http://www.dfcs.georgia.gov.

SNAP PENALTY WARNINGS

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 SNAP or EBT cards that are not yours and do not let someone else use yours.
- Do not use SNAP benefits to buy nonfood items such as alcohol or cigarettes or to pay on credit cards.
- Do not trade or sell SNAP or EBT cards for illegal items such as firearms, ammunition or controlled substance (illegal drugs).

Any household member who breaks any of the SNAP rules on purpose can be barred from SNAP 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 receiving SNAP benefits for an additional 18 months if court ordered.

Any household member who intentionally breaks the rules may not get SNAP benefits 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 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 SNAP 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 SNAP 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 SNAP benefits, you or that household member will be ineligible to participate in SNAP for a period of 10 years.

Only US citizens and qualified aliens are eligible for SNAP benefits. Any non-citizens or non-qualified aliens may be left off your application for assistance. Such persons will not be reported to the Immigration and Customs Enforcement Agency. Non-citizens included on your application will have eligibility determined under the SNAP rules. The income and resources of all individuals in your household will be considered in determining eligibility for persons included on the SNAP application.

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, 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 SNAP/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, in the gross amount of $4500 or more (before taxes or other amounts are withheld). I will report these winnings no later than 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.

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.

Signature of Applicant	Date	Signature of witness if signed by mark
Signature of Authorized Representative	Date	Signature of witness if signed by mark

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, Suite 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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(Keep this document for your information)

Notice of ADA/Section 504 Rights

Help for People with Disabilities

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

The Department provides 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 Department is 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 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, but you do not have to use a form to make a request.

How to File a Complaint

You have the right to make a complaint if the Department has 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 and ADA/Section 504 Coordinator at 47 Trinity Avenue, SW, Atlanta, GA 30334, (877) 423-4746.

You can ask your case worker for a copy of the DFCS civil rights 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 any 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 "Nondiscrimination Statement".

**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.*

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Do Not Send Applications to the USDA

Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.
To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Under the Department of Human Services (DHS), you may also file other discrimination complaints by contacting your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at Georgia Department of Human Services, Office of General Counsel, 47 Trinity Avenue SW, Atlanta, GA 30334, (877) 423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at Georgia Department of Human Services, Office of General Counsel, 47 Trinity Avenue SW, Atlanta, GA 30334, or call (877) 423-4746.

Do Not Send Applications to the USDA