DCH/Katie Beckett Full Renewal Packet

Please return directly to the address: DCH/Katie Beckett Unit

2211 Beaver Ruin Rd. Suite 150 Norcross, GA. 30071

If you have any questions, please contact our office at:

(678) 248-7449 – Phone

(678) 248-7459 - Fax

Georgia Department of Human Services
SNAP/MEDICAID/TANF Renewal Form

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).

For Office Use only: Date Received _____ Client ID # _____ Date Initiated: _____
Programs Initiated: ☐ TANF ☐ SNAP ☐ Medicaid

If you are reapplying for SNAP or renewing your TANF or Medicaid benefits, you can file this renewal/application form with only your name, address, and signature. **However, it will help us to process your application, recertification/renewal more quickly if you complete the entire form and provide verification of information, if it is requested.** You may use this form to file a joint renewal/application for the SNAP/Medicaid and/or TANF program or for SNAP only. Your SNAP renewal will not be terminated solely on the basis that your renewal/application for another program has been denied/terminated. We will make a separate eligibility determination for your SNAP renewal.

Please PRINT the name and address of the person who is reapplying for benefits in the space below:

Client Name:	Date of Birth:	Social Security Number: (Optional for Non-Applicants*)
Are you homeless? Yes _____No _____		*See Citizenship Immigration Status & Social Security Numbers below.
Street Address:		
Mailing Address:		
Main Phone Number:	Other Contact Number:	
Electronic Communication: Email: Yes ____or No ____(optional) Texting: Yes ____or No ____(optional)	Email Address: (optional)	
What is your Preferred Language?	If an interview is required, will you need an interpreter?	Yes____or 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?

I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are noncitizen(s) lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge. I understand and agree that DHS-DFCS, DCH 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 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: Date

Witness Signature if signed by 'X' Date

Pathways Medical Assistance:

Pathways Medical Assistance is a program that provides free or reduced cost Medicaid coverage to individuals ages 19 to 64, who have household income up to 100% of the Federal Poverty Level (FPL), not otherwise eligible for Medicaid and who meet the eligibility requirements. If you would like to be considered for Pathways, please also complete Attachment D.

Authorized Representative:

Complete this section only if you want a person or an organization to fill out your application/renewal, complete your interview for SNAP or TANF, and/or use your SNAP EBT card to buy food when you cannot go to the store. Please check for each program type who you want to designate as an authorized representative. Please check which duties you want the person or organization to have. If you are applying for Medicaid, you can choose more than one person to apply for Medical Assistance on your behalf.

Authorized Representative 1 Program Types: SNAP ❑ TANF ❑ Medical Assistance ❑
Authorized Representative 1 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 ❑
Receive a TANF benefit card (Way2Go) ❑

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 ___

Authorized Representative 2 Program Types: SNAP ❑ TANF ❑ Medical Assistance ❑
Authorized Representative 2 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 ❑
Receive a TANF benefit card (Way2Go) ❑

Person Name 2: _____
Organization Name 2 (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? _____

For Medicaid only:

Do you expect 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 ❑ No If **yes**, please answer questions a, b, and c. If No, please answer 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 anyone be claimed as a tax dependent on someone else's return? ❑ Yes ❑ No
If **yes**, list the name of the tax filer and the tax dependents: _____
How is the tax dependent related to the tax filer? _____

COMMUNITY OUTREACH SERVICES:
For more information about other DHS services, please visit our website at www.dfcs.georgia.gov or call (877) 423-4746.
Please answer all questions and provide proof of all income and any expenses as requested.

CITIZENSHIP IMMIGRATION STATUS AND SOCIAL SECURITY NUMBERS:

Please fill out the chart below about the applicant and all household members. The following federal laws and regulations: The Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7. C.F.R. § 273.2, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, authorize DFCS to request you and your household members Social Security number(s). Anyone who is living in your household and is not applying for benefits may be treated as a **non-applicant**. Non-applicants do not have to give us information about their Social Security number, citizenship, or immigration status and are not eligible for benefits. Other household members may still be able to receive benefits if they are otherwise eligible. If you want us to decide whether any household members are eligible for benefits, you will still need to tell us about their citizenship or immigration status and give us their Social Security number (SSN). You will still need to tell us about **their** income and resources to determine the eligibility and benefit level of the household. We will not report any non-applicant household members to the United States Citizenship and Immigration Services (USCIS) Systematic Alien Verification for Entitlements (SAVE) system if they do not give us their citizenship or immigration status. However, if immigration status information has been submitted on your application, this information may be subject to verification through the SAVE system and may affect the household's eligibility and benefit level. We will match your information with other Federal, state, and local agencies to verify your income and eligibility. This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a SNAP claim, the information on this application, including SSN, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim. We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status. If you are applying for emergency medical services only, you do not have to provide your SSN or information about your immigration status.

First Name	M I	Last Name	Ethnicity Hispanic or Latino? (Optional)	Race (Optional)	Sex M/F	Date Of Birth Format (mm/dd/yy)	Relationship To You	Social Security Number (Optional for Non-Applicants)	Are you a U.S citizen, U.S. National, qualified immigrant or in a satisfactory immigration status? (Applicants only) (Y/N)	Does the mother of this child live in the home? (Y/N)	Does the father of this child live in the home? (Y/N)	Do you want Medicaid? (Y/N)
			Y/N				SELF		Y/N	Y/N	Y/N	Y/N
			Y/N						Y/N	Y/N	Y/N	Y/N
			Y/N						Y/N	Y/N	Y/N	Y/N
			Y/N						Y/N	Y/N	Y/N	Y/N
			Y/N						Y/N	Y/N	Y/N	Y/N
			Y/N						Y/N	Y/N	Y/N	Y/N
			Y/N						Y/N	Y/N	Y/N	Y/N

Race Codes (Choose all that apply):
AI – American Indian or Alaska Native **AS** – Asian **BL** – Black or African American
HP – Native Hawaiian or Other Pacific Islander **WH** – White

By providing Race/Ethnicity 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. However, if you do not provide this information, visual identification of race and ethnicity will be made during the first face-to-face interview.

If you or other household applicants are a Naturalized Citizen, or a qualified alien/immigrant complete the following chart:
(please add additional pages as needed)

NAME First Middle Initial Last	Immigration document type	Alien/Certificate/Document ID number	Have you lived in the U.S. since 1996? (Y/N)	Date Naturalized/Date of Entry or Admission into U.S. (if applicable) Format (mm/dd/yy)	Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? (Y/N)

For Medicaid only:

Was anyone in your household in Foster Care at age 18? ☐ Yes ☐ No
If you have tax dependents that do not live in the home with you, please list below.

Name: _____ Social Security Number _____ Sex: M F (please circle one)
Date of Birth: _____ Citizenship: _____
Relationship to you: _____(please add additional pages as needed)

Tell Us More about the Applicant and All Household Members

We need more information about the applicant and all household members in order to decide who is eligible for benefits. Please answer only the questions about the benefits you want to receive on the page below.

1. Has anyone received any benefits in another county or state? (For SNAP and TANF only)
   ❑ Yes ❑ No

   If **yes**:
   Who: _____
   Where: _____
   When: _____

2. 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 8/22/1996? (For SNAP only) ❑ Yes ❑ No

   If **yes**:
   Who: _____
   Where: _____
   When: _____

3. Did anyone in your household voluntarily quit a job or voluntarily reduce his/her work hours below 30 hours per week within 30 days of the date of application? (For SNAP and TANF only) ❑ Yes ❑ No

   If **yes**, who quit? _____
   Why did he/she quit?_____

4. Is anyone pregnant? (This question does not apply to SNAP applicants) ❑ Yes ❑ No

   If **yes**, Name of pregnant woman: _____
   What is the estimated due date? _____; and how many babies expected? _____

   If no, did anyone in the household deliver or was a pregnancy terminated within the last 12 months? ❑ Yes ❑ No

   If **yes**, Name of pregnant woman: _____
   What was the delivery/termination date? _____; and how many babies were delivered/expected? _____

   *For TANF applicants only please provide the following:
   Unborn baby's father's name: _____ Father's address:_____

5. For Medicaid applicants, does anyone have any unpaid medical bills for the last 3 months? ❑ Yes ❑ No
   If **yes**, please send the unpaid bills if you have a Medicaid case.

6. Is anyone disqualified from the SNAP or TANF Program? (For SNAP and TANF only) ❑ Yes ❑ No

   If **yes**:
   Who: _____
   Where: _____

7. Is anyone fleeing to avoid prosecution or jail for a felony? (For SNAP and TANF only) ❑ Yes ❑ No
   If **yes**, who: _____

8. Is anyone violating conditions of probation or parole? (For SNAP and TANF only) ❑ Yes ❑ No
   If **yes**, who: _____

9. Does anyone have a felony conviction because of behavior related to the possession, use or distribution of a controlled drug substance (i.e., drug felon) after 8/22/1996 (For SNAP and TANF only) or a violent felony (For TANF only)? ❑ Yes ❑ No

   If **yes**:
   Who: _____When: _____

   a. Are you in compliance with the terms of probation related to any sentence received as a result of a drug felony conviction? (For SNAP only) ❑ 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? (For SNAP only) ❑ Yes ❑ No

   c. Have you successfully completed **all the terms of probation or parole** related to any drug related conviction? (For SNAP only) ❑ Yes ❑ No

10. Have you or any household member been convicted of trading SNAP benefits for drugs after 8/22/1996? (For SNAP only) ❑ Yes ❑ No

    If **yes**:
    Who: _____When: _____

11. Have you or any household member been convicted of buying or selling SNAP benefits over $500 after 8/22/1996? (For SNAP only) ❑ Yes ❑ No

    If **yes**:
    Who: _____
    When: _____

12. Have you or any household member been convicted of trading SNAP benefits for guns, ammunition, or explosives after 8/22/1996? (For SNAP only) ❑ Yes ❑ No

    If **yes**:
    Who: _____
    When: _____

13. 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 2/7/2014? (For SNAP only) ❑ Yes ❑ No

    If **yes**:
    Who: _____
    When: _____

    a. Are you in compliance with the terms of probation related to any sentence received as a result of a felony conviction? (For SNAP only) ❑ Yes ❑ No

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

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

14. Have you or any household member received lottery or gambling winnings? ❑ Yes ❑ No

If **yes**:
Who: _____When: _____Amount Received: _____

15. Has anyone used TANF funds or the Way2Go Card at the following establishments, liquor stores, casinos, poker rooms, adult entertainment business, bail bonds, night clubs, salons/taverns, bingo halls, racetracks, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons? (For TANF only) ❑ Yes ❑ No

If **yes**:
Who: _____When: _____

16. Is anyone who is applying for benefits, currently receiving alimony? ❑ Yes ❑ No

If **yes**:
Who: _____
Monthly Amount Received: _____
Date alimony agreement finalized or last modified: _____

For SNAP and TANF only:

STUDENTS IN HIGHER EDUCATION: Is anyone in your household enrolled at least half-time in a college, university, vocational or technical school? ❑ Yes ❑ No If **yes**, who: _____
School Name:_____Grade/Status:_____Graduation date:_____
Is the student employed? ❑ Yes ❑ No Enrolled in work study? ❑ Yes ❑ No
If **yes**, hours worked per week_____(Please complete the employment section below as well.)

For SNAP only:

Does anyone age 60 or older or disabled have medical expenses? ❑ Yes ❑ No
Did your medical expenses such as Medicare premiums, prescription drug cost, or hospital bills change? ❑Yes ❑ No
If yes, list expenses on the chart below and attach bills for the most recent month(s).

Household Member Billed	Type of Expense (Doctor, Hospital, Prescription)	Amount Owed	Date of Bill	Will Insurance Pay? Yes/No

Does anyone 60 years of age or older or disabled have medical expenses for transportation? ❑Yes ❑ No
If yes, please provide the information below. If you are receiving Medicaid, provide proof:

Purpose of the trip (doctor or hospital visit; pharmacy pick- up)	Total miles driven:	Cost of taxi, bus, parking, or lodging:

Does someone else pay any of these medical expenses for you? ❑Yes ❑ No
If yes, please provide information below:

Which expense is paid?	Who pays the expense?
To whom does this person pay the bills?	Address:

For Medicaid only:

OTHER HEALTH COVERAGE

Is anyone enrolled in health insurance now from the following?

☐ Georgia Department of Human Services Medicaid · PeachCare for Kids® · Medicare

☐ VA Healthcare Programs · TRICARE (Don't check if you have direct care or Line of Duty)

☐ Employer Insurance: Name of Insurance_____Policy Number_____

☐ Other: Name of Insurance_____Policy Number_____

Do you have any health insurance **other than** Medicaid? ❑Yes ❑ No

If yes, send us a copy of your insurance card.

RESOURCES:

(Not needed for MAGI Medicaid): Does any person in your household have any of the following resources?

❑ Yes ❑ No (If yes provide the information below. If you are receiving Aged, Blind or Disabled Medicaid (other than Medicare Savings Plans such as QMB, SLMB or QI-1 only) provide proof.

Resource Type	Owner	Account/Policy # (Do not complete If your account/policy # is the same as your SSN)	Value	Name of Bank, Insurance Company etc.
Cash				
Checking/Savings				
Credit Union				
Annuities				
Stocks or Bonds				
Safe Deposit Box				
Retirement Account (For non-MAGI)				
Vehicles (For non-MAGI)				
CD's/Annuities (For non-MAGI)				
Pre-Paid Funeral Plans				
Cemetery Plots (For non-MAGI)				
Trust Funds (For non-MAGI)				
Non-Home Place Property				
Home Place Property (For non-MAGI)				
Life Insurance (For non-MAGI)				
Other				

For Aged, Blind or Disabled Medicaid only:

Have you, your spouse or someone you are applying for sold, traded, or given away a resource in the last 60 months. ❑Yes ❑No

If **yes**, what? _____ When? _____

For SNAP, TANF, and Medicaid:

EMPLOYMENT: Does anyone in your household work? ❑ Yes ❑ No
If yes, list information of the employed person's pay from employment such as wages, bonus, and tips, and attach proof of ALL gross income received in the last 4 weeks.

PERSON WORKING	EMPLOYER	PAY PER HOUR	HOURS PER WEEK	HOW OFTEN PAID	DATE(S) PAID	BONUS PAY	TIPS

Is anyone currently on strike? ❑ Yes ❑ No

For Medicaid only:

PRE-TAX EXPENSES:

- Health Insurance $_____How often?_____
- Dental Insurance $_____How often?_____
- Other Deduction Type $_____How often?_____
- Other Deduction Type $_____How often?_____
  More? Please attach on a separate sheet of paper.
- Vision Insurance $_____ How often?_____
- Other Deduction Type $_____How often?_____
- Other Deduction Type $_____How often?_____

Pre-Tax expenses are deductions taken out of your income before taxes are applied. Not all deductions are pre-tax.

TAX RETURN DEDUCTIONS:

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

NOTE: You shouldn't include a cost that you already considered in your answer to self-employment.

- Alimony Paid $_____ How often?_____
- Other Deduction Type $_____ How often?_____
- Student Loan Interest $_____ How often?_____
- Other Deduction Type $_____ How often?_____

For SNAP, TANF, and Medicaid:

Has anyone stopped working? ❑Yes ❑ No If yes, complete the following and provide proof:

What job stopped?	Name of Household Member who stopped working:	
Place of employment:		
Date Pay Stopped:	Date of Final Check:	Amount of final Pay (gross):

Has anyone started working? ❑Yes ❑ No If yes, complete the following and provide proof:

Name of person who started working:	Date Started:	Phone Number:
Name of employer/business:	Rate of Pay: $	Date first check received/will be received:
How often paid (please check one): • Weekly • Bi-weekly • Twice a month • Monthly • Other		

SELF-EMPLOYMENT:

Is anyone self-employed: ❑Yes ❑ No (If **yes**, who?) _____

Please provide proof of self-employment income through tax files, business records, receipts, bills, or statements from customers of an established business.

Is this business incorporated? ❑Yes ❑ No

Does this person have any self-employment expenses? ❑Yes ❑ No

If **yes**, what type of expenses does this person have? _____

For Medicaid and TANF only: provide proof for self-employment expenses.

UNEARNED INCOME:

Does anyone in your household receive money from Contributions, Social Security, SSI, VA, Child Support, Unemployment, Retirement, or any other income? ❑Yes ❑ No

If **yes**, complete the information below and provide proof of all income received in the last 4 weeks or the most recent award letter.

Name	Source	Amount	How Often?

For MAGI Medicaid: Income from child support, veteran's payment, Supplemental Security Income (SSI), or worker's compensation benefits will not be counted.

DEPENDENT CARE COSTS:

Do you pay for the care of a dependent child or a disabled adult household member? ❑Yes ❑ No

If **yes**, complete the questions below.

Person who requires care:		Person who pays for care:	
Provider's Name:		How much provider is paid:	How often paid:
Provider's Phone #:	Reason for Care:		

Do you pay transportation expenses for a dependent child or disabled adult household member? ❑Yes ❑ No

Are these expenses included in the dependent care expenses? ❑Yes ❑ No

If **no**, please answer this question: **Total miles driven weekly**: _____

SHELTER COSTS:

Did you or any household member start paying shelter costs or did your shelter costs change? ❑Yes ❑No

If yes, complete the chart below.

Expense	Amount	How Often?	Who paid?
Rent/Mortgage			
Property Taxes			
Property Insurance			
Electricity			
Gas			
Fuel oil/Wood/ Kerosene			
Well/Septic Tank/Water/Sewage			
Garbage			
Telephone			
Other			

What is the home's primary heating or cooling source? (electricity, gas, or both)

Does someone else pay any of these household bills for you? ❑Yes ❑No **If yes, complete the chart below:**

Who pays the bill?	What bills are paid?
What amount is paid?	To whom does this person pay the bills?

Have you received energy assistance (LIHEAP) in the last 12 months? ❑Yes ❑No

If **yes**, amount received $ _____

Do you share monthly household expenses with anyone in the home? ❑Yes ❑No

If **yes**, who? _____

Comments/Documentation_____

Paid to whom_____Amount paid $_____per _____

Landlord Name_____Landlord Address _____

CHILD SUPPORT PAYMENT:

Do you or someone in your household pay child support to someone living outside of the home? ❑Yes ❑No

If **yes**, complete the chart below:

Who is obligated to pay?	How much is the obligated amount?
For whom is the child support paid?	How much is the actual amount paid?
To whom is the child support paid?	How often is the child support paid?

For SNAP only: Please provide proof of the amount paid in the past 3 months and the amount legally obligated to pay.

This section is FOR TANF RECIPIENTS ONLY – You must complete the following:

Shot Records:

Is there any child under age 7, who is not yet enrolled in school? (Pre-K is **not** considered "school.")

❑Yes ❑No

If **yes**, send Form 3231- Child Care Immunization form for each child under age 7.

School Requirements:

Are all children (6-18 yrs. old) attending school? ❑Yes ❑No

If **yes**, name(s) of child(ren) _____

Name of school(s) _____

Grade(s) _____

Is there any child 16 years of age or older who is **not** in school? ❑Yes ❑No

If **yes**, name of child/children? _____

_____

Please provide a copy of current check stubs if this child is **employed** or a statement from the provider if engaged **in any other work-related activity.**

Domestic Violence:

Are you or anyone in your household a victim of Domestic Violence, Sexual Harassment, Sexual Assault, or Stalking? ❑Yes ❑ No

If **yes**, please let us know the name of victim _____

After assessment, if your household qualifies, we can waive certain program requirements, such as, participation in work activities or referral to the Division of Child Support Services.

Auto Expense:

Are you the parent or a relative of the child (or children) and are you included in the TANF AU with the child (or with the children)? ❑Yes ❑No

If **yes**, answer the following questions:

Do you or any other adult AU member own or is purchasing an automobile? ❑Yes ❑No

If **yes**, who? (Name of owner) _____

_____

Year, Make and Model of the vehicle: _____

Please list automobile note payments, Insurance, Maintenance, and other related expenses:

_____ _____ _____ _____

Do you have any other recurring expenses (for example credit card bills) that you are paying? ❑Yes ❑No

If **yes**, please list: _____

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), Temporary Assistance for Needy Families (TANF), Refugee Cash Assistance (RCA), Child Care and Parent Services (CAPS), or Women, Infants and Children (WIC) into the Medical Assistance program.

The Division of Family and Children Services (DFCS) will use the household size, residency, and income information from SNAP, TANF, RCA, CAPS or WIC, but DFCS will verify citizenship or immigration status using Medical Assistance rules to make an ELE determination to automatically enroll or renew the children in Medicaid or PeachCare for Kids®. DFCS will send a determination notice once completed, let members make any changes and allow them to opt out of the ELE process or terminate the Medical Assistance case at any time.

RIGHTS AND RESPONSIBILITIES FOR ALL PROGRAMS

YOU HAVE THE RIGHT TO:

- **request assistance filling out this form and free language assistance services** (interpreters, translated materials, or direct in-language services) if you have trouble reading, writing, speaking, or understanding the English language.
- **request auxiliary aids and services and reasonable modifications** if you or someone in your household has a disability.

HEARING NOTICE: In all programs you have the right to request a fair hearing in writing or in person. You may ask for a hearing by calling 1-877-423-4746 or you may ask for a hearing before a state hearings officer if you do not agree with this decision. You may be represented at the hearing by a lawyer, relative, friend or anyone you choose. If you want a hearing, you must ask for the hearing in writing or by contacting the agency within:

- **90 days** from the date of this notice **for SNAP**
- **30 days** from the date of this notice **for Medicaid and TANF**

YOU ARE RESPONSIBLE FOR:

- giving your worker correct information and providing proof of statements needed to receive benefits. When you sign this form, you are giving your worker permission to get information from your employer, bank, neighbor, or others so we can make sure you are receiving the correct amount of benefits.
- telling the truth at all times. If you or someone who is applying for you provides incorrect information, you may be committing a crime, and you may go to jail.
- providing proof that you or anyone in your household applying for benefits is a U.S. citizen or eligible immigrant.
- cooperating with state and federal personnel who work for Fraud Prevention or the Office of Investigative Services and who are doing special case reviews. If you do not cooperate and we cannot determine that you are still eligible for SNAP, your case may be denied or closed.
- (for SNAP) cooperating with Quality Control reviewers when they call or come to your home to interview you about the information you have given your case manager. If you do not cooperate with them, your case may be denied or closed.
- (for SNAP and TANF) repaying benefits you should not have received.
- (for Medicaid) cooperating with Medicaid Eligibility Quality Control or Program Integrity when they call or come to your home to interview you about the information you have given your case manager.
- (for Medicaid) members who are in a Nursing Home, Intermediate Care Facility, Community-Based Service, or are enrolled in and receive services through a waiver program, cooperating with Estate Recovery.

If you receive **SNAP**, you must report when your household's total monthly gross income is more than 130% of the Federal Poverty Level for your household size. You must report the change in income no later than 10 days from the end of the month in which the change occurred.

If you are a working adult with no children, you must report when your work hours are less than 20 hours a week or 80 hours per month. You must report these changes no later than 10 days from the end of the month in which the change occurred.

You must also report when your household receives substantial lottery and gambling winnings. This is a cash prize won in a single game. If you or a household member receives lottery or gambling winnings, in the gross amount of $4500 or more (before taxes or other amounts are withheld), you must report these winnings no later than 10 days from the end of the month in which the household received the winnings.

If you receive **TANF or Medicaid**, you must report **all changes** in your situation within 10 days of the change occurring.

I understand that any lump sum or "windfall" payment that any person in my Medicaid case receives must be budgeted, along with any other income that we might have, to determine eligibility.

In the **Medicaid** Program, you have a right to:

- Receive Medicaid even if you have other health insurance.
- Choose your Medicaid doctor or provider.
- Have your Medicaid application approved or denied within 10, 45, or 90 days from the date you apply, depending on the type of Medicaid.

As a condition of my Medicaid eligibility:

- I agree to assign to the State all rights to medical support and to payment for medical care from any third party (hospital and medical benefits).
- I agree to cooperate with the State in identifying and providing information to assist the State in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days. (If you are completing this form on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described above as a condition of his/her eligibility for Medicaid).
- I agree to give the State the right to require an absent parent to 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.

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).

Anyone in your household who breaks <u>any</u> of these rules on purpose can be barred from SNAP from one year to permanently, fined up to $250,000, imprisoned for 20 years or both. She/he may be subject to prosecution under other applicable Federal and State laws and may also be barred from SNAP for an additional 18 months if court ordered.

Anyone in your household who intentionally breaks the rules may not get SNAP 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 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.

I understand that if I give false information or withhold information, I may be prosecuted for fraud.

TANF PROGRAM PENALTY WARNINGS: In the TANF Program, an intentional action by providing false or misleading information to establish or maintain an AU's eligibility, increase benefits, prevent a decrease in benefits, withholding information to avoid a negative action or using the cash assistance at prohibited places is considered an Intentional Program Violation.

You may be referred to the Office of Inspector General to determine your penalty based on the severity of the offense if you:

- do not report changes on time or do not tell the truth or use the cash assistance funds or TANF Debit card to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities "strip clubs", poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, race tracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons is strictly prohibited, give false information about where you live so you can receive benefits in more than one state and convicted of a drug-related charge or a serious violent felony, on or after 1/1/97.

Anyone in your household who breaks these rules on purpose can be barred from the TANF program from six months to permanently.

For MEDICAID, committing fraud or abuse is against the law. You may be referred to the Medicaid and PeachCare for Kids® Program Integrity Unit. Violators may be limited to using one provider, terminated from the program, or asked to reimburse the Department of Community Health for medical services provided.
Fraud is a dishonest act done on purpose. Abuse is an act that does not follow good practices.

Examples of participant fraud and abuse are:

- Letting someone else use your Medicaid, PeachCare for Kids® or CMO health insurance card
- Getting prescriptions with the intent of abusing or selling drugs
- Using forged documents to get services
- Misusing or abusing equipment that is provided by Medicaid or PeachCare for Kids®
- Providing incorrect information or allowing others to do so in order to obtain Medicaid or PeachCare for Kids® eligibility
- Failure to report changes which occur in income, living arrangements, or resources

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 Martin Luther King Jr. Drive SE, 19th Floor, East Tower, Atlanta GA 30334; or visit https://dch.georgia.gov/report-medicaidpeachcare-kids-fraud.

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.

IF YOU ARE RENEWING YOUR MEDICAID AND SNAP OR TANF, YOU MUST SIGN AND DATE IN THE BOX THAT BEST FITS YOUR SITUATION.

PLEASE RETURN THIS FORM PRIOR TO THE CERTIFICATION END DATE TO BEGIN THE RENEWAL PROCESS.

- **For Medicaid only – sign here when the Applicant/Member/Legal Guardian is completing:**

If I am applying for/renewing Medicaid for myself, I declare under penalty of perjury that I am a U.S. Citizen, U.S. National and/or qualified immigrant present 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 and/or qualified immigrant in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge.

_____ _____
(Signature) (Date)

- **For Medicaid only – sign here when a Person Other Than Applicant/Member/Parent/Legal Guardian is completing:**

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

_____ _____
(Signature) (Date)

Phone where you can be reached _____

If the Applicant/Member/Parent/Legal Guardian wants this person as the personal representative, she or he must check here and sign below ☐ Yes ☐ No

_____ _____
(Applicant/Member/Parent/Legal Guardian) (Date)

- **For SNAP and/or TANF – when the Applicant/Recipient/Legal Guardian is completing:**

I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are noncitizen(s) lawfully present in the United States. I further certify that all the information provided on this application is true and correct to the best of my knowledge. I understand and agree that DHS-DFCS, DCH 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 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) (Date)

(Keep these documents for your information)

This chart explains some of the terms used on this form.

Applicant	An individual who applies to receive public assistance or benefits.
Assistance Unit (AU)	An assistance unit includes eligible individuals who live together, including a pregnant individual and an unborn child, and receive public assistance/benefits.
Caretaker	A parent, pregnant individual, relative or legal guardian who applies for and receives TANF with children in his or her care, including an unborn child.
Client ID	A unique number assigned to an individual receiving public assistance/benefits.
Disqualified	The action taken to remove an individual from a SNAP or TANF case because they did not tell the truth and received benefits that they should not have received.
Domestic Violence	Domestic violence can include being hit, kicked, beaten, raped, choked, threatened, controlled, or kept from getting what you need to live (such as food, medicine, or a home) by a spouse, boyfriend/girlfriend,, partner, or "ex".
Electronic Benefit Transfer (EBT)	The system used in Georgia to pay benefits to individuals who are eligible for SNAP. Individuals receiving assistance are issued an EBT debit card, which is used to access their SNAP accounts.
Electronic Communications	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.
Grantee Relative	A parent, pregnant individual, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children, including an unborn child.
Gross Income	A person's total income before taking taxes or other deductions into account.
Homeless Individual	An individual who lacks a fixed and regular nighttime residence or an individual whose primary nighttime residence is: • a supervised shelter designed to provide temporary accommodations (such as a welfare hotel or congregate shelter); • a halfway house or similar institution that provides temporary residence for individuals intended to be institutionalized; • a temporary accommodation for not more than 90 days in the residence of another individual; or a place not designed for, or ordinarily used, as a regular sleeping accommodation for human beings (a hallway, a bus station, a lobby, or similar places).
Household Members	Individuals who live in your home. For SNAP, individuals who live together and purchase and prepare their meals together.
Income	Payments such as wages, salaries, commissions, bonuses, worker's compensation, disability, pension, retirement benefits, interest, child support or any other form of money received.
Middle Class Tax Relief Act of 2012	This Act prohibits the use of cash assistance funds or TANF Debit Cards to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities, poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, racetracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons. The use of cash assistance funds or the TANF Debit Card at these businesses will constitute an intentional program violation (fraud) on the part of the recipient.
Non-applicant	An individual who does NOT apply for or receive public assistance/benefits. Non-applicants are not required to provide a social security number, citizenship, or immigration status.
Payee	A payee is an individual who accepts responsibility for receiving cash assistance and spending the funds on behalf of the AU. A payee may or may not be an AU member.
Pre-Tax Expenses	Pre-Tax expenses are deductions taken out of your income before taxes are applied. Not all deductions are pre-tax. Most common pre-tax deductions are health insurance, dental insurance, vision insurance, etc. http://www.irs.gov

Qualified Alien/Immigrant	A *qualified alien/immigrant* is a person who is legally residing in the U.S. who falls within one of the following categories: • a person *lawfully admitted for permanent residence* (LPR) under the Immigration and Nationality Act (INA); • *Amerasian* immigrant under section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988; • A person who is *granted asylum* under section 208 of the INA; • *Refugees*, admitted under section 207 of the INA; • A person *paroled* as a refugee or asylee under section 212 (d)(5) of the INA; • A person whose *deportation* is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or section 241(b)(3) of the INA, as amended; • A person who is *granted conditional entry* under section 203(a)(7) of the INA as in effect prior to April 1, 1980; • *Cuban or Haitian* immigrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980; • *Victims of human trafficking* under section 107(b)(1) of the Trafficking Victims Protection Act of 2000; • *Battered immigrants* who meet the conditions set forth in section 431 (c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended; • *Afghan or Iraqi* immigrants granted special immigrant status under section 101(a)(27) of the INA (subject to specified conditions*);* • *American Indians* born in Canada living in the U.S. under section 289 of the INA or non-citizens of federally-recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and; • *Hmong or Highland Laotian tribal members* that rendered assistance to U.S. personnel by taking part in military or rescue operation during Vietnam Era (8/05/1964 – 5/07/1975). For Medical Assistance applicants only, Compact of Free Association (COFA) are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau. COFA migrants do not have to meet the 5-year bar.
Resources	Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance.
Sexual Assault	Nonconsensual sexual act proscribed by Federal, Tribal, or State law, including when the victim lacks capacity to consent.
Sexual Harassment	Hostile, intimidating, or oppressive behavior based on sex that creates an offensive work environment.
Stalking	The act or crime of willfully and repeatedly following or harassing another person in circumstances that would cause a reasonable person to fear injury or death especially because of express or implied threats.
Taxable Income	Payments such as wages, salaries, commissions, bonuses, disability, pension, retirement benefits, interest, or any other form of money received.
Tax Dependent	An individual who expects to be claimed on a tax filer's tax return. http://www.irs.gov
Tax Filer	An individual who expects to file a tax return. http://www.irs.gov
Tax Return Deductions	Tax return deductions are the allowable IRS deductions found on your tax return form 1040, starting with line 23 to line 35. They include: Educator expenses; Form 2106; Health Savings Form 8889; Moving Expenses Form 3909; Penalty/Early Withdrawal of Savings; Alimony Paid; IRA Deduction; Student Loan Interest; Tuition and Fees Form 8917; Domestic Production Activities Form 8903. http://www.irs.gov
Trafficking in SNAP	*Trafficking* SNAP benefits means: (1) Buying, selling, stealing, or otherwise exchanging SNAP benefits issued and accessed via EBT cards, card numbers and PIN numbers or by manual voucher and signature, for CASH or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; (2) The exchange of firearms, ammunition, explosives, or controlled substances; (3) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount; (4) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; (5) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food. (6) Attempting to buy, sell, steal, or otherwise affect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone.
Way2Go Debit Mastercard	The State of Georgia has implemented a convenient "electronic" payment option for the TANF recipients called the Way2Go Debit MasterCard. Under this payment option, money is deposited in the recipient's account on the first calendar day of the month. If the first falls on a weekend or holiday, benefits are made available on the last business day of the prior month. The recipient has immediate access to his or her funds because the funds are electronically loaded to the Debit MasterCard.

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 at the KB office, online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, or you may email your modification request to DCH.ADAassistance@dch.ga.gov.

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 47 Trinity Avenue SW, Atlanta, GA 30334, (877) 423-4746. For DCH, contact the KB Team ADA/Section 504 Coordinator at 2211 Beaver Ruin Road, Suite 150, Norcross, GA 30071 or P.O. Box 172, Norcross, GA 30091, (678) 248-7449. The DCH email is: dch.adarequests@dch.ga.gov.

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 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. The link for the DCH Civil Rights process and complaint form is located at: https://dch.georgia.gov/adasection-504-and-civil-rights.

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" 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 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.

Do Not Send Applications to the USDA or HHS

Nondiscrimination Statement

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on 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 in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for 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 who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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. **phone:** (833) 620-1071; or
4. **email:** FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

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, (877) 423-4746.

Do Not Send Applications to the USDA or HHS

GEORGIA DEPARTMENT OF COMMUNITY HEALTH – THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE

CASE NAME:_____ CASE NO:_____

ADDRESS: _____ SSN: _____

_____ PHONE NO:_____

TYPE OF CASE: ☐ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION
(Check all that apply) ☐ HIPP REFERRAL EFFECTIVE DATE OF CHANGE OR CANCELLATION:____/____/____

The information obtained on this form is collected by the Georgia Department of Community Health, Third Party Liability Section. The collection of this information is authorized by law (42 U.S.C. 1396(a) (25): 42 CFR 433.135-139). It will be used to determine the liability of third parties to pay for care and services and collection of that liability. Medicaid benefits are not denied based on any applicant having health insurance or medical coverage.

Do you have a private, group or government health insurance that pays any of the cost of your medical care? (Do not include Medicare or Medicaid) ☐ YES ☐ NO Does your spouse, parent or stepparent have any private, group or government health insurance that pays any of the cost of your medical care? ☐ YES ☐ NO	Is policyholder an Absent Parent? ☐ YES ☐ NO

Names of Covered Individuals in Household (Last) (First) (MI)	Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
			Policy Holder	Spouse	Child	Step-child	Other	

Are any of these persons pregnant? ☐ YES ☐ NO If yes, Name _____ Date of Delivery_____

ATTACH A COPY OF INSURANCE CARD/POLICY AND A COPY OF SNT

Do any of the persons listed above have a chronic medical condition? ☐ YES ☐ NO If yes, Name_____ Condition_____

_____(_____)_____
(Insurance Company Name) (Telephone Number)

_____
(Address) (City) (State) (Zip)

_____
(Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

_____
(Policy Effective Date) (Policy Termination Date)

_____
(Employer Name) (Telephone Number)

_____
(Employer Address) (City) (State) (Zip)

Types of Coverage (circle those which apply)

01 – HOSPITAL INPT.	15 – LTC/NH
07 – DRUG/STND	16 – HMO/DRUG
08 – MAJOR MED.	17 – MED. SUPP A
09 – DENTAL	18 – MED. SUPP B
10 – VISION	22 – HMO/STND

OTHER_____

I authorize the release of information necessary to identify health/liability insurance benefits to the Department of Community Health. I also certify that the above information is correct.

Signed_____ Date_____
Member or Authorized Person

I hereby assign to the Department of Community Health all rights to payments for benefits of medical services rendered to myself or any of my dependents who receive Medicaid.

Signed_____ Date_____
Insured or Authorized Person

EFFECTVIE DATE OF MEDICAID ELIGIBILITY_____

Case Worker Name:_____ Phone No:_____ County_____

DMA-285-REV. (01/06)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Gainwell Technologies/HIPP UNIT – 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084 Tel: (678) 564-1162, Option 1
Fax: (800) 817-1769 Email: hippga@gainwelltechnologies.com

APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

Head of Household:		Referral Source:	
Address:		Address:	
City:	State:	City:	State:
Zip:	Telephone #	Zip:	Telephone #

1. Complete the following information regarding your health insurance policy.

Policyholder's Name:_____ Insurance Co. Name:_____
Policy Number:_____ Insurance Co. Address:_____
Group Number:_____ City/State/Zip:_____
Policyholder's Social Security Number:_____ Telephone #:_____
Policyholder's Date of Birth:_____ Policyholder's Email:_____

2. Is the policy referenced in #1 the primary policy? **YES_____** **NO_____**

3. Is there a secondary policy with another employer? **YES_____** **NO_____**
(If yes, please provide the information for the secondary policy on a separate page)

4. Complete the following information regarding the employer offering the policy referenced in #1.

Employer Name:_____ Employer Address:_____
Employer Telephone:_____ City/State/Zip:_____

5. List all Medicaid eligible persons covered under this policy (use back of application for additional space).

NAME	SOCIAL SECURITY NUMBER	BIRTHDATE	MEDICAID ID #	RELATIONSHIP TO POLICYHOLDER	MALE/ FEMALE
1.		/ /			
2.		/ /			
3.		/ /			
4.		/ /			
5.		/ /			

6. Are any of these persons pregnant? **YES_____** **NO_____**

If yes:

Name **Expected Date of Delivery** **Name** **Expected Date of Delivery**

_____ / / _____ / /

7. Have any of the persons in #5 been diagnosed with a medical condition? If yes, please list all medical conditions or diagnosis (please provide a separate page if additional space is needed).

Name **Condition**

YES _____ **NO** _____

_____

8. If known, how much are the premiums for this policy? $_____

9. How often is the premium amount paid?

❑ WEEKLY ❑ BIWEEKLY ❑ SEMIMONTHLY ❑ MONTHLY ❑ QUARTERLY ❑ OTHER

10. Complete the following information if COBRA benefits may be available from a former employer:
Have you received COBRA forms? **YES** ____**NO**____Date COBRA forms received ____/____/____
Last Date of Employment ____/____/____**(Please attach copy of COBRA enrollment packet to this application)**

11. Can we contact your employer and/or insurance carrier to verify this information? YES_____NO_____

12. Do you authorize the GA HIPP Unit to send communication via electronic mail to the policyholder's email address provided above? YES_____NO _____

13. I certify under the penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge.

14. Please sign and date this application (TO BE SIGNED BY POLICYHOLDER ONLY).

_____ _____
Policyholder's Signature **Date**

6Ai Instructions for Form DMA-6(A): Physician's Recommendation for Pediatric Care

Instructions: It is important that EVERY item on the DMA-6(A) is answered, even if it is answered as N/A (not applicable). Make sure that the physician or nurse who completes some of the sections is aware of this requirement. The form is only valid for 90 days from the date of the physician's signature. The form should be completed as follows:

Section A – Identifying Information Section A of the form should be completed by **the parent or the legal representative** of the Katie Beckett child unless otherwise noted. All reference to "the applicant" means the child for whom Medicaid is being applied for.	
Item #	**Instructions**
Item 1: Applicant's Name/Address	Enter the complete name and address of the applicant including the city and ZIP code. For DFCS County enter the applicant's county of residence.
Item 2: Medicaid Number	To be completed by county staff.
Item 3: Social Security Number	Enter the applicant's nine-digit Social Security number.
Item 4 & 4A: Sex, Age and Birthdate	Enter the applicant's sex, age, and date of birth.
Item 5: Primary Care Physician	Enter the entire name of the applicant's Primary Care Physician.
Item 6: Applicant's Telephone Number	Enter the telephone number, including area code, of the applicant's parent or the legal representative.
Item 7: Does guardian think the applicant should be institutionalized?	If the Katie Beckett applicant were not eligible under this category of Medicaid, would s/he be appropriate for placement in a nursing facility or institution for the intellectually disabled. Check the appropriate box.
Item 8: Does the child attend school?	Check the appropriate box.
Item 9: Date of Medicaid Application	To be completed by county staff.
Fields below Item 9:	Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, include the name of the caregiver.
Item 10: Signature	Read the statement below the name(s) of the caregiver(s), and then, the parent or legal representative for the applicant should sign the DMA-6(A) legibly.
Item 11: Date	Please record the date the DMA-6 (A) was signed by the parent or the legal representative.

Section B - Physician's Examination Report and Recommendation This section must be completed in its entirety by the Katie Beckett child's **Primary Care Physician. No item should be left blank unless indicated below.**	
Item 12: History	Attach additional sheet(s) if needed. Describe the applicant's medical history (Hospital records may be attached).
Item 13: Diagnosis	Add attachment(s) for additional diagnoses. Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Please note the ICD codes. Depending on the diagnosis, a psychological evaluation may be required. If you have an evaluation conducted within the past three years, include a copy with this packet.
Item 13A: ICD-10 Diagnosis Code	Add attachment(s) for additional diagnoses. Describe the primary, secondary, and any third ICD-10 diagnoses relevant to the applicant's condition on the appropriate lines.
Item 14: Medications	Add attachment(s) for additional medication(s). The name of all medications the applicant is to receive must be listed. Include name of drugs with dosages, routes, and frequencies of administration.
Item 15: Diagnostic and Treatment Procedures	Include all diagnostic or treatment procedures and frequencies.

Item 16: Treatment Plan	Attach copy of order sheet if more convenient or other pertinent documentation. List previous hospitalization dates, as well as rehabilitative and other health care services the applicant has received or is currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.
Item 17: Anticipated Dates of Hospitalization	List any anticipated dates of hospitalization for the applicant. Enter N/A if not applicable.
Item 18: Level of Care Recommended	Check the correct box for the recommended level of care; nursing facility, hospital, or intermediate care facility for the intellectually disabled. If left blank or N/A is entered, it is assumed that the physician does not deem this applicant appropriate for institutional care.
Item 19: Type of Recommendation	Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.
Item: 20: Patient Transferred From	Check one. Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.
Item 21: Length of Time Care Needed	Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box for permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.
Item 22: Is Patient Free of Communicable Diseases?	Check the appropriate box.
Item 23: Alternatives to Nursing Facility Placement	The admitting or attending physician must indicate whether the applicant's condition could be managed by provision of the Community Care or Home Health Care Services Programs. Check either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate.
Item 24: Physician's Name and Address	Print the admitting or attending physician's name and address in the spaces provided.
Item 25: Certification Statement of the Physician and Signature	The admitting or attending physician must certify that the applicant requires the level of care provided by a hospital, nursing facility or an intermediate care facility for the intellectually disabled. **This must be an original signature; signature stamps are not acceptable.** If the physician does not deem this applicant appropriate for institutional care, enter N/A and sign.
Item 26: Date Signed by the Physician	Enter the date the physician signs the form.
Item 27: Physician's Licensure Number	Enter the attending or admitting physician's license number.
Item 28: Physician's Telephone Number	Enter the attending or admitting physician's telephone number including area code.

Section C - Evaluation of Nursing Care Needed **Check appropriate boxes only.** This section may be completed by the Katie Beckett child's **Primary Care Physician or a registered nurse** who is well aware of the child's condition.	
Items 29 - 38	Check each appropriate box.
Item 39: Other Therapy Visits	If applicable, check the appropriate box for the number of treatment or therapy sessions per week the applicant receives or needs. Enter N/A, if not applicable.
Item 40: Remarks	Enter additional remarks if needed or "None".
Item 41: Pre-admission Certification Number	Leave this item blank.
Item 42: Date Signed	Enter the date this section of the form is completed.
Item 43: Print Name of MD or RN/Signature of MD or RN	The individual completing Section C should print their name legibly and sign the DMA-6(A).**This must be an original signature; signature stamps are not acceptable**.
Items 44 - 52	Do Not Write Below This Line. Items 44 through 52 are completed by Contractor staff only.

Type of Program: ☐ Nursing Facility ☐ GAPP ☐ TEFRA/Katie Beckett ☐ ICF/ID

PEDIATRIC DMA 6(A)

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:

DFCS County _____

_____
Mailing Address

2. Medicaid Number:

3. Social Security Number

4. Sex | Age | 4A. Birthdate

5. Primary Care Physician

6. Applicant's Telephone #

7. In the caretaker's opinion, would the child require institutionalization if the child did not receive community services? ☐ Yes ☐ No

8. Does child attend school? ☐ Yes ☐ No

9. Date of Medicaid Application / /

Name of Caregiver #1: _____ Name of Caregiver #2: _____

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Department of Community Health and the Department of Human Resources, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

10. Signature: _____ 11. Date: _____
(Parent or other Legal Representative)

Section B – Physician's Report and Recommendation

12. History: *(attach additional sheet if needed)*

13. Diagnosis | 1. ICD | 2. ICD | 3. ICD

1) _____ 2) _____ 3) _____
(Add attachment for additional diagnoses)

14. **Medications**

Name	Dosage	Route	Frequency

15. **Diagnostic and Treatment Procedures**

Type	Frequency

16. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)**

Previous Hospitalizations: _____ Rehabilitative/Habilitative Services: _____ Other Health Services: _____

Hospital Diagnosis: 1) _____ 2) Secondary _____ 3) Other _____

17. Anticipated Dates of Hospitalization: _____ / _____

18. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ ICF/ID Facility

19. Type of Recommendation:
☐ Initial
☐ Change Level Care
☐ Continued Placement

20. Patient Transferred from (check one):
☐ Hospital ☐ Another NF
☐ Private Pay ☐ Lives at home

21. Length of Time Care Needed _____ Months
1) ☐ Permanent
2) ☐ Temporary _____ estimated

22. Is patient free of communicable diseases?
☐ Yes ☐ No

23. This patient's condition could be managed by provision of ☐ Community Care or ☐ Home Health Services

24. Physician's Name (Print):

Physician's Address (Print):

25. I certify that this patient requires the level of care provided by a hospital, nursing facility, or ICF/ID

Physician's Signature:

26. Date signed by Physician

27. Physician's Licensure No.

28. Physician's Telephone #: ( )

Section C– Evaluation of Nursing Care Needed (check appropriate box only)

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral Status
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/ GT Meds	☐ Age Dependent Incontinence ☐ Incontinent - Age >3 ☐ Colostomy ☐ Continent ☐ Other	☐ Monitoring ☐ CPAP/Bi-PAP) ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs >2/day ☐ Therapy ☐ Oxygen ☐ Home Vent ☐ Trach ☐ Nebulizer Tx ☐ Suctioning ☐ Chest - Physical Tx ☐ Room Air	☐ Prosthesis ☐ Splints ☐ Unable to ambulate > 18 months old ☐ Wheelchair ☐ Normal	☐ Agitated ☐ Cooperative ☐ Alert ☐ Developmental Delay ☐ Mental Retardation ☐ Behavioral Problems ☐ (please describe, if checked) ☐ Suicidal ☐ Hostile

34. Integument System	35. Urogenital	36. Surgery	37. Therapy/Visits	38. Neurological Status
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☐ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age >3 ☐ Catheterization ☐ Continent	☐ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	☐ Day care Services ☐ High Tech - 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 per month ☐ None	☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal

39. Other Therapy Visits

☐ Five days per week ☐ Less than 5 days per week

40. Remarks

41. Pre-Admission Certification Number

42. Date Signed

43. Print Name of MD or RN:_____

Signature of MD or RN:

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date:_____ Admission Date_____Approved for_____Days or_____Months

45. Are nursing services, rehabilitative/habilitative services or other health related services requested ordinarily provided in an institution?

☐Yes ☐No ☐NA

47. Hospitalization Precertification ☐Met ☐Not Met

46A. State Authority MH & MR Screening)

Level I/II

Restricted Auth. Code Date

46B. This is not a re-admission for OBRA purposes

Restricted Auth. Code Date

48. Level of Care Recommended by Contractor

☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

49. Approval Period	50. Signature (Contractor)	51. Date / /	52. Attachments (Contractor) ☐Yes ☐No	
	_____			

TEFRA/Katie Beckett Medical Necessity/Level of Care Statement Instructions for Completion DMA Form 706

This document provides detailed instructions for completion of the TEFRA/Katie Beckett Medical Necessity/Level of Care Statement. It may be completed by physician and the primary caregiver.

Member (Applicant) Information
Enter the Member's Name, DOB and SS#.

Diagnosis
Enter the Member's primary, secondary, and any third diagnoses relevant to the member's condition.

Level of Care
Check the correct box for the recommended level of care.

Medical History
Provide narrative of member's medical history or attach documents (i.e., hospital discharge summary, etc.)

Current Needs
Check member's current needs and provide description of skilled nursing needs.

Therapy
Therapies require a plan of care. All therapies, including school based therapies, must be ordered by a physician and accompanied by current individually signed therapy notes.

Hospitalizations
Attach most recent hospital discharge summary and document date, reason and duration.

School
Enter a check for member's appropriate school attendance and IFSP or IEP plan

Signature
The primary care physician or physician of record must sign and date. The caregiver (parent or guardian) must sign and date. Foster Care members must have the signature of the DFCS representative.

TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name: _____DOB: _____SS#: _____

Diagnosis: _____

_____

Recommended level of Care:

- ☐ Nursing facility level of care
- ☐ Hospital level of care
- ☐ Level of care required in an Intermediate Care Facility for ID (ICF-ID)

Medical History: (May attach hospital discharge summary or provide narrative):

_____

_____

		Current Needs
	None	Description of Skilled Nursing Needs
Cardiovascular:	_____	_____
Neurological:	_____	_____
Respiration	_____	_____
Nutrition:	_____	_____
Integumentary:	_____	_____
Urogenital:	_____	_____
Bowel:	_____	_____
Endocrine:	_____	_____
Immune:	_____	_____
Skeletal:	_____	_____
Other:	_____	_____

Therapy (Attach current notes): Speech sessions/wk_____PT sessions/wk_____OT sessions/wk_____
Autism Spectrum Services/wk_____

Hospitalizations within the last 12 months: (Attach most recent hospital discharge summary)
Date: _____ Reason: _____ Duration: _____

Comments: _____

_____

Child in school: _____ Hrs per day _____Days per wk _____N/A_____IEP/IFSP_____

Nurse in attendance during school day: ____No ____Yes (Attach most recent month's nursing notes)

Skilled Nursing hours received: Hrs/day_____ N/A____

I attest that the above information is accurate, and this member meets Pediatric Level of Care Criteria and requires the skilled care that is ordinarily provided in a nursing facility, hospital, or facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

Physician's Signature: _____ Date: _____

Primary Caregiver/Parent/Guardian Signature: _____ Date: _____

Foster Care Applicants must have the signature of the DFCS representative.

(DMA 706)

(Rev. 05/2025)

Instructions for Completing the Katie Beckett Cost Effectiveness Form

DMA Form 704

This form should be completed by the Katie Beckett child's primary physician.

Instruct the physician to complete the form as follows:

- Patient Name – Enter the name of the Katie Beckett child.
- The MES may provide the Medicaid number, if not known.
- The physician should enter the diagnosis name (not the ICD code) and the prognosis in the spaces provided. S/he may attach additional information if needed.
- The physician should provide the estimated monthly cost of any of the medical services which the Katie Beckett child regularly receives. If the physician will not complete the everything applicable, it is permissible to have other medical service amounts entered by the providing agency, pharmacy or therapist; have that entity initial next to the dollar amount; at the very least, the physician must complete the cost of his/her services.
- The physician must indicate if home care will be as good as institutional care.
- It is not necessary to enter any comments. However, it will be helpful to the MES if you will indicate for each medical service the percentage amount that is covered by any private/group insurance plan.
- The form must have an original signature of the primary care physician.
  Stamped signature are not acceptable. The date should be the date of the signature.

TEFRA/Katie Beckett

Cost-Effectiveness Form

(Child's physician must complete Form)

The following information is requested for the purpose of determining your patient's eligibility for Medicaid:

Patient's Name:_____ Medicaid #:_____

Diagnosis:_____

Prognosis:_____

Please provide the estimated **monthly** costs of Medicaid services your patient will need or is seeking for Medicaid to cover for in-home care:

- Physician's services $_____
- Durable medical equipment _____
- Drugs _____
- Therapy(s) _____
- Skilled Nursing Services _____
- Other(s)_____ _____

TOTAL $_____

Will home care be as good or better than institutional care?

_____ Yes _____ No

COMMENTS:

_____

_____

_____

_____

PHYSICIAN'S SIGNATURE _____

DATE: _____

DMA Form 704
Rev. 10-04

Department of Community Health

DCH Centralized Katie Beckett Unit

All therapies whether in school or private setting must be medically necessary.

Please provide supporting documentation:

- Current individual signed and dated therapy notes for the last 90 days.
- Signed physician orders for all therapies, specifying how many times per week each therapy service is medically necessary.

Failure to provide the supporting documentation by the time requested may result in the closure of your Katie Beckett Medicaid case or denial of your Katie Beckett Medicaid application.

Supplemental Evaluation Documents

DEVELOPMENTAL EVALUATION (Current no more than 3 years old)

Required for all Children with Developmental Delays-**Ages 0 to 5** such as ones listed below:

Cerebral Palsy, Epilepsy, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder, or other Developmental Delays.

Licensed Professionals approved to perform Developmental Evaluations are as follows:

- **Developmental** Pediatricians
- Psychologist with:
  - Ph.D
- School Psychologist, Preschool Diagnosticians, and Education Diagnosticians with the following degrees:

  M.Ed M.A CAS Psy.S SSP
  Ed.S M.S CAGS Psy.D Ed.D

EIS-Early Intervention Specialist with Babies Can't Wait are accepted for children with an individual Family Service Plan (IFSP). Also, an IFSP or/and Individualized Family Service Plan (IEP) must be submitted if in place.

The Developmental report MUST be signed by an approved Evaluator and Must contain:
STANDARD SCORES or **AGE EQUIVALENTS** in these **FIVE DOMAINS OF FUNCTION**:

COGNITION, LANGUAGE, MOTOR, ADAPTIVE, and SOCIAL

PSYCHOLOGICAL EVALUATION (Current no more than 3 years old)

Required for all Children with Developmental Delays-**Ages 6 to 18** such as ones listed below:

Cerebral Palsy, Epilepsy Cerebral, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder, or other Developmental Delays.

Licensed Professionals approved to perform Developmental Evaluations are as follows:

- **Developmental** Pediatricians
- Psychologist with:
  - Ph.D

- School Psychologist, Preschool Diagnosticians, and Education Diagnosticians with the following degrees:

  M.Ed M.A CAS Psy.S SSP
  Ed.S M.S CAGS Psy.D Ed.D

The Psychological report **M**UST be signed by an approved Evaluator and **MUST** contain an **IQ** score **AND Adaptive Function testing including an overall Composite Score**.

A current Psychological or Developmental Evaluation is always required when the recommended Level of Care (LOC) is ICF/MR and/or the Behavioral Status, (#33 on form DMA-6A) is anything other than alert and/or cooperative.

Revised 6/2023

Notice of Privacy Practices
Georgia Department of Human Services

***Date*: December 01, 2023**

THIS NOTICE DESCRIBES HOW HEALTH (MEDICAL) AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

The Department of Human Services (DHS) is an agency of the Executive Branch of Georgia government charged with the administration of numerous federal programs responsible for the storage, use and maintenance of medical and other confidential information. Federal and state laws establish strict requirements for these programs regarding the use and disclosure of confidential and protected information. DHS is required to comply with those laws as noted throughout this notice.

Protecting your privacy is very important to us. This Notice of Privacy Practices tells you our obligations, what information we collect, how the Department may use and disclose your information, and your rights.

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

- Maintain the privacy of all your personal information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice currently in effect.

INFORMATION WE COLLECT:

We collect information necessary to verify identity, citizenship status, residency, income, and incarceration status. This information includes but is not limited to:

- Demographic data such as name, address, telephone number, email, and age;
- Income data such as tax filing status, marriage status, tax dependents, employer, and income;
- Citizenship and immigration data such as social security number, resident alien number, and incarceration status; and
- Medical information such as disabilities, any health insurance coverage, and other information necessary to facilitate your application for benefits/services.

HOW DHS MAY USE AND DISCLOSE PERSONALLY IDENTIFIABLE INFORMATION:

Personally Identifiable Information (PII) is collected, used, maintained, and shared by DHS. We collect PII during your application for benefits and/or services. The information provided is verified and confirmed through various sources. The following describes some ways DHS may use and disclose personally identifiable information that identifies you:

- For eligibility determination; and
- For enrollment in DHS programs;

The PII provided to DHS by clients is purposely used to determine eligibility, approve, deny, or renew public assistance benefits. The data is maintained for the purpose of renewing benefits by verifying the eligibility, support agency denial, and approval on renewal decisions. The data is shared to effectuate the purpose of the programs. We will not create, collect, use or disclose PII for any purposes that are not authorized by law.

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes some ways DHS may use and disclose protected health information that identifies you ("Health Information"):

As Required by Law. DHS will disclose Health Information when required to do so by federal, state or local law.

For Treatment. DHS may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, DHS may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in your medical care and need the information to provide you with medical care.

For Payment. DHS may use and disclose Health Information so that DHS or others may bill and receive payment related to your care, an insurance company, or a third party for the treatment and services you received. For example, DHS may provide your health plan information so that treatment may be paid for.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, DHS may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. DHS also may disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, DHS may use and disclose Health Information for research. Before DHS uses or discloses Health Information for research, the project will go through a special approval process. Even without special approval, DHS may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Business Associates. DHS may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, DHS may utilize the services of a separate entity to perform information technology services. All DHS business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, DHS may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE DHS TO PROVIDE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:

Individuals Involved in Your Care or Payment for Your Care. Unless you object, DHS may disclose to a member of your family, a relative, a close friend or any other person you identify, your Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, DHS may disclose such information as necessary if it is determined that it is in your best interest based on the professional judgment of DHS.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your Health Information will be made only with your written authorization:

1. Uses and disclosures of Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Health Information.

Your written permission is necessary before your health records are shared for any other reason not authorized by law. If you do provide DHS with a written authorization, you may revoke it at any time by submitting a written revocation to the Privacy Officer at the contact information below. Upon receipt, DHS will no longer disclose Health Information under the authorization. However, disclosures made in reliance upon your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding information DHS has about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing. DHS has up to 30 days to make your Health Information available to you and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. DHS will make every effort to provide access to your Health Information in the form or format you request if it is readily producible in such form or format. If the Health Information is not readily producible in the form or format you request, your record will be provided in our standard electronic format. If you do not want this form or format, a readable hard copy form will be provided. DHS may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information (PHI) and PII.

Right to Amend. If you feel that DHS has incorrect or incomplete information about you, you may request DHS to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To make changes, you can go through your user portal, contact customer service for the program to which you are applying, contact your case manager, or make your request, in writing, to the below referenced Privacy Officer. We encourage you to review your information on a regular basis to make sure it is correct.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures DHS made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information DHS uses or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information DHS discloses to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that DHS not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing. DHS is not required to agree to your request unless you are requesting DHS restrict the use and disclosure of your Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid "out-of-pocket" in full. If DHS agrees, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that DHS communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that DHS only contact you by mail or at work. To request confidential communications, you must make your request, in writing. Your request must specify how or where you wish to be contacted. DHS will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the Privacy Officer. You may also obtain a copy from the DHS website, on the Office of General Counsel homepage:

https://dhs.georgia.gov/organization/about/division-offices/office-general-counsel

PROTECTIONS:

DHS is committed to protecting your personal information. PII and PHI is protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized access, use, and/or disclosure of protected information. We do not sell any information given to us. We strictly adhere to a range of federal and state privacy and information security related standards designed to keep your information secure.

CHANGES TO THIS NOTICE:

DHS reserves the right to change this notice at any time. The new notice applies to information already obtained as well as any information received in the future. DHS will post a copy of the current notice at our office and on the website at https://dhs.georgia.gov/organization/about/division-offices/office-general-counsel. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you have any questions about this notice, please contact:

Georgia Department of Human Services
Privacy Officer
47 Trinity Avenue SW,
Atlanta, GA 30334
HIPAADHS@dhs.ga.gov
(404) 463-0590

If you believe your privacy rights have been violated, you may file a complaint in writing by contacting the above-referenced Privacy Officer. Please include your name, phone number, case number and a description of the complaint. **You will not be penalized for filing a complaint**.

You may also file with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). For more information on HIPAA privacy requirements, HIPAA electronic transactions, and code sets regulations and the proposed HIPAA security rules, please visit U.S. Department of Health and Human Services web site at: https://www.hhs.gov/hipaa/index.html.

If you have questions about your health or your health care services, you should contact your health care provider (physician, pharmacy, hospital and/or other medical provider).

CONSENT:

By submitting your personal information to us, you agree that we may collect, use, and disclose any such information as permitted or required by law.

Signature Page

If you would like to acknowledge receipt of this DHS Notice of Privacy Practices, please sign below, and return this page to the address below.

I have read, understand, and acknowledge receipt of the DHS Notice of Privacy Practices.

_____ _____

Signature Date

_____

Print Name

Notice of Privacy Practices
Georgia Department of Human Services

***Date*: December 01, 2023**

THIS NOTICE DESCRIBES HOW HEALTH (MEDICAL) AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

The Department of Human Services (DHS) is an agency of the Executive Branch of Georgia government charged with the administration of numerous federal programs responsible for the storage, use and maintenance of medical and other confidential information. Federal and state laws establish strict requirements for these programs regarding the use and disclosure of confidential and protected information. DHS is required to comply with those laws as noted throughout this notice.

Protecting your privacy is very important to us. This Notice of Privacy Practices tells you our obligations, what information we collect, how the Department may use and disclose your information, and your rights.

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

- Maintain the privacy of all your personal information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice currently in effect.

INFORMATION WE COLLECT:

We collect information necessary to verify identity, citizenship status, residency, income, and incarceration status. This information includes but is not limited to:

- Demographic data such as name, address, telephone number, email, and age;
- Income data such as tax filing status, marriage status, tax dependents, employer, and income;
- Citizenship and immigration data such as social security number, resident alien number, and incarceration status; and
- Medical information such as disabilities, any health insurance coverage, and other information necessary to facilitate your application for benefits/services.

HOW DHS MAY USE AND DISCLOSE PERSONALLY IDENTIFIABLE INFORMATION:

Personally Identifiable Information (PII) is collected, used, maintained, and shared by DHS. We collect PII during your application for benefits and/or services. The information provided is verified and confirmed through various sources. The following describes some ways DHS may use and disclose personally identifiable information that identifies you:

- For eligibility determination; and
- For enrollment in DHS programs;

The PII provided to DHS by clients is purposely used to determine eligibility, approve, deny, or renew public assistance benefits. The data is maintained for the purpose of renewing benefits by verifying the eligibility, support agency denial, and approval on renewal decisions. The data is shared to effectuate the purpose of the programs. We will not create, collect, use or disclose PII for any purposes that are not authorized by law.

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes some ways DHS may use and disclose protected health information that identifies you ("Health Information"):

As Required by Law. DHS will disclose Health Information when required to do so by federal, state or local law.

For Treatment. DHS may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, DHS may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in your medical care and need the information to provide you with medical care.

For Payment. DHS may use and disclose Health Information so that DHS or others may bill and receive payment related to your care, an insurance company, or a third party for the treatment and services you received. For example, DHS may provide your health plan information so that treatment may be paid for.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, DHS may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. DHS also may disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, DHS may use and disclose Health Information for research. Before DHS uses or discloses Health Information for research, the project will go through a special approval process. Even without special approval, DHS may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Business Associates. DHS may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, DHS may utilize the services of a separate entity to perform information technology services. All DHS business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, DHS may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE DHS TO PROVIDE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:

Individuals Involved in Your Care or Payment for Your Care. Unless you object, DHS may disclose to a member of your family, a relative, a close friend or any other person you identify, your Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, DHS may disclose such information as necessary if it is determined that it is in your best interest based on the professional judgment of DHS.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your Health Information will be made only with your written authorization:

1. Uses and disclosures of Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Health Information.

Your written permission is necessary before your health records are shared for any other reason not authorized by law. If you do provide DHS with a written authorization, you may revoke it at any time by submitting a written revocation to the Privacy Officer at the contact information below. Upon receipt, DHS will no longer disclose Health Information under the authorization. However, disclosures made in reliance upon your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding information DHS has about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing. DHS has up to 30 days to make your Health Information available to you and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. DHS will make every effort to provide access to your Health Information in the form or format you request if it is readily producible in such form or format. If the Health Information is not readily producible in the form or format you request, your record will be provided in our standard electronic format. If you do not want this form or format, a readable hard copy form will be provided. DHS may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

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_____ _____

Signature Date

_____

Print Name

STATE OF GEORGIA APPLICATION FOR VOTER REGISTRATION

Fill out the bottom half of this application by following these directions. Print clearly and use blue or black ink.

1. **LEGAL NAME**. Your full legal name including any suffix such as Sr., Jr., III, is required on this form.
2. **ADDRESS**. Provide residential address. This information is required.
3. **MAILING ADDRESS**. If mailing address is different from residential address, complete the mailing address section.
4. **PERSONAL INFORMATION**. A telephone number is helpful to registration officials if they have a question about your application. Gender and race are requested and are needed to comply with the Voting Rights Act of 1965, but are not mandated by law.
5. **VOTER IDENTIFICATION NUMBER**. Federal law requires you to provide your full GA Drivers License number or GA State issued ID number. If you do not have a GA Drivers License or GA ID you must provide the last 4 digits of your Social Security number. Providing your full Social Security number is optional. Your Social Security number will be kept confidential and may be used for comparison with other state agency databases for voter registration identification purposes. If you do not possess a GA Drivers License or Social Security number please check the appropriate box and a unique identifier will be provided for you.
6. **OATH**. Federal law requires that you answer the citizenship and age questions. Read the oath and sign your name. If you cannot complete this application unassisted because of physical disability or illiteracy, you must either sign or make your mark on the signature line, and the person assisting you MUST sign the signature space for person assisting voter.
7. **POLL OFFICER QUESTION**. Your willingness to be a poll worker will have no bearing on your application for registration.
8. **NAME/ADDRESS CHANGE**. Complete these sections to change the name or address of your current voter registration.
9. **MAP/DIAGRAM**: If you live in an area without house numbers and street names, please include a drawing of your location to assist us in locating your appropriate voting precinct.
10. **DELIVERY INSTRUCTIONS:** Verify that you have completed and signed the application. Enclose a copy of your ID if you are submitting this form by mail and registering for the first time in Georgia. Fold the application in half, remove the tape at the top, and press the edges together. The application is ready for you to mail (postage is prepaid) or deliver to your county voter registration office.
11. **You are NOT officially registered to vote until this application is approved**. You should receive a voter precinct card in the mail. If you do not receive this acknowledgement within two to four weeks after mailing this form, please contact your county voter registration office. You can find your poll location and other election information on the Secretary of State's website at www.sos.ga.gov/elections.

REQUIREMENT: If you are submitting this form by mail and you are registering for the first time in Georgia, you are required to submit proof of residence either with this form OR when you vote for the first time. Proof of residence includes one of the following: a COPY of a current and valid photo ID; or a COPY of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address. You are exempt from this requirement if you are entitled to vote by absentee ballot under the Uniform and Overseas Citizens Absentee Voting Act, or if you provide your Georgia driver's license/ID number (or the last four digits of your social security number if you do not have a driver's license/ID) on this form and your identifying information is verified with a state database.

Place copy of ID in pocket

Trim copy of ID to size

COUNTY PRECINCT	MUNICIPAL PRECINCT	DISTRICT (CD/HD/SD)	CODE OF REGISTRATION SITE	REGISTRATION NO.	CHANGE OF ADDRESS ☐ CHANGE OF NAME ☐ OTHER

1	LAST NAME	FIRST NAME	MIDDLE OR MAIDEN NAME			SUFFIX ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	
2	RESIDENCE ADDRESS: House No. and street name	APT. NO.	CITY	COUNTY	STATE **GA.**	ZIP CODE	
3	MAILING ADDRESS (If different from residence address): Post-office box or route		CITY		STATE	ZIP CODE	
4	TELEPHONE NUMBER ( )	DATE OF BIRTH: MM/DD/YYYY / /	GENDER Male ☐ Female ☐	RACE/ ETHNICITY: ☐ Black ☐ White ☐ Hispanic/Latino ☐ Asian/Pacific Islander ☐ American Indian ☐ Other			
5	VALID GA. DRIVER'S LICENSE OR GA. I.D. NO.	**If no GA Driver's License or GA. I.D. No., must provide last 4 digits of your Social Security Number**	FULL SOCIAL SECURITY NUMBER (OPTIONAL) Last 4 Digits (Required)	☐ Check if you do not have a GA Driver's License, GA. I.D. No. or Social Security No.			

6

(Your answer is required under federal law)

I SWEAR OR AFFIRM:

Are you a citizen of the United States of America? Check One: Yes ☐ No ☐

Will you be 18 years of age on or before election day? Check One: Yes ☐ No ☐

If you checked "No" in response to either of these questions, do not complete this form.

I SWEAR OR AFFIRM THAT:

I reside at the address listed above.
I am eligible to vote in Georgia.
I am not serving a sentence for having been convicted of a felony involving moral turpitude.
I have not been judicially declared to be mentally incompetent.

WARNING: Any person who registers to vote knowing that such person does not possess the qualifications required by law, who registers under any name other than such person's own name, or who knowingly gives false information in registering shall be guilty of a felony. O.C.G.A. § 21-2-561

Date _____ X Signature _____ Signature of person helping illiterate or disabled voter _____

7 May we contact you about working as an Election Day poll officer? Yes ☐ No ☐

If you would like to receive additional information by email, please provide your e-mail address:

8 CHANGE OF NAME: If you are changing your name, list the name under which you were previously registered: Last Name | Suffix | First | Middle or Maiden Name

CHANGE OF ADDRESS: If you are changing your address or if you were previously registered to vote, list your previous address:

CITY | COUNTY | STATE

Military Active Duty? Yes ☐ No ☐

NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 19242 ATLANTA GEORGIA
POSTAGE WILL BE PAID BY ADDRESSEE

SECRETARY OF STATE
STATE OF GEORGIA
PO BOX 105325
ATLANTA GA 30348-9562

STATE OF GEORGIA APPLICATION FOR VOTER REGISTRATION

If you meet the following qualifications, complete this form and **personally mail** to the Secretary of State or **personally** deliver to your county voter registration office. Prepaid postage is provided for your convenience.

QUALIFICATIONS: To register to vote you must:

- Be a **citizen** of the **United States**
- Be a legal **resident** of the **county**
- Be at least **17½** years of age to register and **18 to vote**
- **Not** be serving a sentence for conviction of a **felony** involving moral turpitude
- Have **not** been found **mentally incompetent** by a judge

See other side for complete instructions.

Once you complete and personally mail or deliver your application, you should receive an acknowledgement from the local voter registration office. Generally this process takes two to four weeks. To follow up on your voter registration application or to obtain more information on voter registration and elections, just call your local voter registration office.

GENERAL INFORMATION:
For more information on election dates, registration deadlines, and local county voter registration telephone numbers, see the Secretary of State's website at **www.sos.ga.gov/elections.**

SECRETARY OF STATE
802 West Tower
2 Martin Luther King, Jr. Dr.
SE Atlanta, Georgia 30334-1505
Telephone: (404) 656-2871