DEBBIE DOBBS ADVOCACY, LLC

Special Education Advocate & Medicaid Waiver Consultant

KATIE BECKETT FORM 508 FOR RENEWALS

SAMPLE FORM

Attached is a sample completed form 508, which is **one** of the forms used for renewals for the Katie Beckett Medicaid Application. We have received many questions and comments from families that they are confused and have questions on how to fill out this form. This form replaces Form 222, which used to be used for renewals.

PLEASE NOTE: THIS IS JUST A SAMPLE AND YOU WILL NEED TO ANSWER THE QUESTIONS AS IT PERTAINS TO YOU AND YOUR FAMILY. THERE MAY BE OTHER SECTIONS THAT WOULD BE PERTINENT TO COMPLETE IN YOUR SITUATION OR QUESTIONS THAT MAY BE ANSWERED DIFFERENTLY. All SECTIONS THAT DO NOT NEED TO BE COMPLETED HAVE BEEN CROSSED OFF.

IF YOU HAVE ANY QUESTIONS ON COMPLETING THIS FORM FOR YOUR FAMILY, PLEASE CONTACT THE KATIE BECKETT OFFICE AT 678-248-7449.

Disclaimer: Nothing in this document is intended as legal or medical advice.

Georgia Department of Human Services
FOOD STAMP/MEDICAID/TANF Renewal Form

If you need help reading or completing this document or need help communicating with us, ask us or call 1-877-423-4746. 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 Load #_____Client ID # _____Date Initiated_____
Programs Initiated: ☐ TANF ☐ Food Stamps ☐ Medicaid

If you are reapplying for Food Stamps 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 Food Stamp/Medicaid and/or TANF program or for the Food Stamp Program (FS) only. Your Food Stamp 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 Food Stamp renewal.

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

Client Name: Baby Bear	Date of Birth: 01-01-2010	Social Security Number: 555-55-5555
Street Address: 1234 Forest Glen Rd		
Mountain Glen, GA 30041		
Mailing Address: Same As Above		
Main Phone Number: Mama Bear 888-888-8888	Other Contact Number: Papa Bear 888-888-4444 (Optional)	Email Address: papabear@gmail.com
E-mail Communication Yes X or No ___ (optional) mamabear@gmail.com	Texting: Yes X or No __(optional)	
What is your Preferred Language? English	If an interview is required, will you need an interpreter? Yes ____ or No X	

~~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 Food Stamp/Medicaid and/or TANF program requirements. I will also report If anyone in my household receives lottery or gambling winnings, gross amount of $3500 or more (before taxes or other amounts are withheld). I will report these winnings within 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 at my application or renewal interview and/or fail to verify them that DHS-DFCS will not budget that expense in calculating the amount of my Food Stamp benefits.

Signature: Date

Please sign with pen. Please use black ink

Witness Signature if signed by 'X'

Date

Authorized Representative:

Complete this section only if you want someone to fill out your application/renewal, complete your interview for Food Stamps or TANF, and/or use your Food Stamp EBT card to buy food when you cannot go to the store. If you are applying for Medicaid, you can choose more than one person to apply for Medical Assistance on your behalf.

Name 1: Mama Bear Phone: 888-888-8888

Address: 1234 Forest Glen Apt: _____

City: Mountain Glen State: GA Zip: 30041

Preferred Language: English Is an interpreter needed? Yes ____ or No X

Name 2: Papa Bear Phone: 888-888-4444

Address: 1234 Forest Glen Apt: _____

City: Mountain Glen State: GA Zip: 30041

Preferred Language: English Is an interpreter needed? Yes ____ or No X

For Medicaid, do you want this individual to have a copy of your Medicaid card? ☒ Yes ☐ 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 X (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~~** **~~If Yes, Please answer questions a, b, and c~~** ☐ **~~NO~~** **~~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 you be claimed as a dependent on someone's tax return? ☐Yes ☐No~~

~~If yes, list the name of the tax filer:~~ _____

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COMMUNITY OUTREACH SERVICES:
For more information about other DHS services, please visit our website at www.dfcs.georgia.gov or call 1-877-423-4746.

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 Food Stamp 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	MI	Last Name	Ethnicity Hispanic or Latino? (Optional)	Race (Optional)	Sex M/F	Date Of Birth	Relationship To You	Social Security Number (Applicants only)	Are you a U.S citizen, 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)
Baby		Bear	Y/N		F	01-01-2010	SELF	555-55-5555	Y	Y	Y	Y
Mama		Bear	Y/N		F	02-02-2003	Mother		Y	N/A	N/A	N/A
Papa		Bear	Y/N		M	02-02-2005	Father		Y	N/A	N/A	N/A
Jr		Bear	Y/N		M	12-01-2019	Sibling		Y	Y	Y	N/A

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.

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)

For Food Stamp Program only - DISQUALIFICATIONS:

(1) Have you or any household member been convicted of giving false information about where they live and who they are to get multiple FS benefits in more than one area after 8/22/96? Yes ☐ No ☐

If yes, Who:_____Where:_____When: _____

(2) Do you or any household member have a felony conviction because of behavior related to the possession, use or distribution of a controlled substance after 8/22/96? Yes ☐ No ☐

If yes, Who:_____When: _____

Date of offense:_____Date of Conviction: _____

Does this person have 1st Offender Status? Yes ☐ No ☐

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

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

(3) Is anyone trying to avoid prosecution or jail for a felony?Yes ☐No ☐

If yes, who _____

(4) Is anyone violating conditions of probation or parole? Yes ☐ No ☐

If yes, who _____

(5) Have you or any household member been convicted of trading SNAP benefits for drugs after 8/22/96? Yes ☐ No ☐

If yes, who;_____when: _____

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

If yes, who;_____when: _____

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

If yes, who;_____when: _____

(8) Have you or any household member received lottery or gambling winnings? ❑ Yes ❑ No

If yes, who: _____when: _____

Amount received: _____

For the TANF Program only - DISQUALIFICATIONS

(1) Has anyone been convicted of a violent felony? Yes ☐ No ☐

If yes, who: _____

(2) Has anyone been convicted on or after January 1997 of misrepresenting their residency in order to receive TANF benefits in multiple states? Yes ☐ No ☐

If yes, who: _____

(3) Has anyone been convicted of using the TANF cash assistance or TANF debit MasterCard at prohibited places listed below: liquor stores, casinos, poker rooms, adult entertainment business, bail bonds, night clubs/salons/taverns, bingo halls, race tracks, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons. Yes ☐ No ☐

If yes, who:_____ when: _____

Food Stamps 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 Medicaid and TANF Only:

Is anyone in your household pregnant?

Yes ☐ No ☐ Number of expected births:_____ Name of pregnant woman: _____

Baby's Due Date: _____ Unborn baby's father's Name: _____

Father's address: _____

_____

MEDICAL:

For Medicaid Only:

Does anyone in the household have any unpaid medical bills? Yes ☐ No ☐

If yes, please send the unpaid bills if you have a Medicaid case.

For Food Stamps 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 chart below. Attach bills, prescription drugs for 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 ALL INSURANCE Policy Number XYZ12345678
☐ 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 Medicaid/TANF only)~~				
~~Vehicles (For non-MAGI Medicaid/TANF only)~~				
~~CD's/Annuities (For non-MAGI Medicaid/TANF only)~~				
~~Pre-Paid Funeral Plans (For non-MAGI Medicaid/TANF only)~~				
~~Cemetery Plots (For non-MAGI Medicaid/TANF only)~~				
~~Trust Funds (For non-MAGI Medicaid/TANF only)~~				
~~Non-Home Place Property (For non-MAGI Medicaid/TANF only)~~				
~~Home Place Property (For non-MAGI Medicaid/TANF only)~~				
~~Life Insurance (For non-MAGI Medicaid/TANF only)~~				
~~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?~~ _____

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
Please see attached Paycheck stubs or Tax Return							

For Medicaid only

Please see attached paycheck stubs or Tax return

PRE-TAX EXPENSES:

☐ Health Insurance $____ How Often? _____ How Often? _____ ☐ Vision Insurance $_____

☐ Dental Insurance $_____ How Often? _____ ☐ Other Deduction Type: _____

$_____How Often? _____

☐ Other Deduction Type: _____ $_____ How Often?_____☐ Other Deduction Type: _____ $_____

How Often?_____☐ Other Deduction Type:_____$_____How Often? _____

☐ More? Please attach on a separate sheet of paper.

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

TAX RETURN DEDUCTIONS: **Please See attached paycheck stubs or Tax return**

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?_____☐ Student Loan Interest $_____

How Often? _____

☐ Other Deduction Type_____$_____

How Often? _____

Did anyone in your household voluntarily quit a job or voluntarily reduce his/her work hours to below 30 hours per week within the last 30 days of the date of this renewal? Yes ☐ No ☒

If yes, who quit?_____Date of quit: _____

What Job was quit? _____

Why did he/she quit? _____

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 Workman'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; provide proof for **Food Stamps** (if the monthly amount is over $200).

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, air conditioner)
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 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 Food Stamps only, please provide proof of amount paid in the past 3 months and the legal obligation 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? Yes ☐ No ☐

If yes, please let us know the name of domestic violence 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: _____

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 Food Stamps (SNAP)**
- **30 days** from the date of this notice **for Medicaid and TANF**

The Medicaid program cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs. To report eligibility or provider discrimination, call the Georgia Department of Community Health's Office of Program Integrity (local) 404-463-7590 or (toll free) 800-533-0686.

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 Food Stamps, your case may be denied or closed.
- (for Food Stamps) 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 Food Stamps 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 55 years or older and 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 **Food Stamps**, you must report when your total monthly gross income goes over the income limit for your household size. 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 the 10th day 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, gross amount of $3500 or more (before taxes or other amounts are withheld), you must report these winnings within 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 60 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.

FOOD STAMP (SNAP) PROGRAM 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 Food Stamps or EBT cards that are not yours and do not let someone else use yours.
- Do not use Food benefits to buy nonfood items such as alcohol or cigarettes or to pay on credit cards.
- Do not trade or sell Food Stamps 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 the Food Stamp Program 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 the Food Stamp/SNAP program for an additional 18 months if court ordered.

Anyone in your household who intentionally breaks the rules may not get Food Stamps 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 the Food Stamp Program 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 the Food Stamp Program 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 Food Stamp benefits, you or that household member will be ineligible to participate in the Food Stamp Program 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® Fraud Control 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

You should report instances of fraud and abuse to:

Medicaid/ PeachCare for Kids® Fraud & Abuse Hotline (404) 463-7590 or toll free at (800) 533-0686 or by US Mail at:
Department of Community Health, OIG PI Section, 2 Peachtree Street, NW 5th Floor,
Atlanta, GA 30303.

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

__X__ No

_____ I do not want to answer the Voter Registration question

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at:
2 Martin Luther King Jr. Drive, Suite 802, West Tower, Atlanta, GA 30334 or by calling 404-656-2871.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration application from your caseworker. If you complete a Voter Registration application, submit it to the Georgia Secretary of State's Office following the instructions provided on the Voter Registration application.

PLEASE SIGN & DATE BELOW IN THE BOX THAT BEST FITS YOUR SITUATION.

IF YOU ARE RENEWING YOUR MEDICAID AND FOOD STAMPS OR TANF, YOU MUST SIGN AND DATE EITHER BOX ① OR BOX ② AND BOX ③.

PLEASE RETURN THIS FORM BYTHE 10th OF THE FOLLOWING MONTH OR AT LEAST TWO DAYS PRIOR TO YOUR FOOD STAMP APPOINTMNENT.

① 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 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 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.

Please sign with pen. Please use black ink

_____ _____

(Signature) (Date)

② 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) 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)

③ For Food Stamps 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 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 Food Stamp/Medicaid and/or TANF program requirements. I will also report If anyone in my household receives lottery or gambling winnings, gross amount of $3500 or more (before taxes or other amounts are withheld). I will report these winnings within 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 at my application or renewal interview and/or fail to verify them that DHS-DFCS will not budget that expense in calculating the amount of my food stamp benefits.

_____ _____

(Signature) (Date)

(Keep these documents for your information)

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

Applicant	An individual who chooses to apply for or to receive public assistance/benefits.
Assistance Unit (AU)	An assistance unit includes *eligible* individuals who live together and receive public assistance/benefits.
Caretaker	A parent, relative or legal guardian who applies for and receives TANF with children in his or her care.
Client Id	A unique number assigned to an individual receiving public assistance/benefits.
Disqualified	The action taken to remove an individual from a Food Stamp or TANF case because they did not tell the truth and received benefits that they should not have received.
Electronic Benefit Transfer (EBT)	The system used in Georgia to pay benefits to individuals who are eligible for Food Stamps. Individuals receiving assistance are issued an EBT debit card, which is used to access their food stamp accounts.
EPPICard-Debit MasterCard	The State of Georgia has implemented a convenient "electronic" payment option for the TANF recipients called the EPPICard debit Master Card. Under this payment option money is deposited in the recipient's account on the first calendar day of the month. The recipient has immediate access to his or her funds, because the funds are electronically loaded to the debit MasterCard.
Grantee Relative	A parent, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children.
Gross Income	A person's total income before taking taxes or other deductions into account.
Household Members	Individuals who live in your home. For Food Stamps, 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, race tracks, 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 an SSN, 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* into the US under section 212(d)(5) of the INA for at least one year; 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).
Resources	Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance.
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 the SNAP/Food Stamp Program	*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.

Notice of ADA/Section 504 Rights

Help for People with Disabilities

The Georgia Department of Human Services and the Georgia Department of Community Health ("the Departments") are required by federal law* to provide persons with disabilities an equal opportunity to participate in and qualify for the Departments' programs, services, or activities. This includes programs such as SNAP, TANF and Medical Assistance. The Departments provide reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities communication assistance, such as sign language interpreters. Our help is free. The Departments are not required to make any modification that would result in a fundamental alteration in the nature of a service, program or activity or in undue financial and administrative burdens.

How to Request a Reasonable Modification or Communication Assistance

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at 404-657-3433 or DCH at 678-248-7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dhs.georgia.gov/forms-notices, or you may obtain the DCH ADA Reasonable Modification Request Form at the DCH Katie Becket Team office or online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, but you do not have to use a form.

How to File a Complaint

You have the right to make a complaint if the Departments have discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street N.W., Ste 19-454, Atlanta, GA, 30303, 404-657-3735. For DCH, contact the KB TEAM ADA/Section 504 Coordinator at 5815 Live Oak Pkwy Suite 2-F, Norcross, GA, 30093, 678-248-7449.

You can ask your case worker for a copy of the DFCS civil rights complaint form. The complaint form is also available at https://dhs.georgia.gov/documents/dfcs-discrimination-complaint-form-0. If you need help making a discrimination complaint, you may contact the DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) is within the "USDA-HHS Joint Nondiscrimination Statement" included within.

**Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.*

Under the **Department of Human Service (DHS)**, you may also file other discrimination complaints by contacting your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street N.W., Ste 19-454, Atlanta, GA, 30303, 404-657-3735. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impaired Program at: Two Peachtree Street, N.W., Suite 29-103 N.W., Atlanta, GA 30303 or call 404-657-5244 (voice), 404-463-7591 (TTY), 404-651-6815 (fax).

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 political or religious beliefs.

To report Medicaid eligibility or provider discrimination, call the Georgia Department of Community Health's Office of Program Integrity **(local 404-463-7590) or (toll free) 800-533-0686**. You may also report suspected Medicaid fraud by calling (toll free) 1-800-533-0686.

Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, 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.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or 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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (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: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (800) 368-1019 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.