



Application for Benefits

YOU MUST HAND DELIVER, FAX or MAIL THE COMPLETED APPLICATION TO YOUR LOCAL COUNTY OFFICE.

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).

What Services Do We Offer at the Division of Family and Children Services (DFCS)?

DFCS offers the following services:

Food Assistance



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Food Stamp (SNAP) benefits can be used to buy food at any store that has the EBT/Quest sign. We will subtract the price of your food purchase from your Food Stamp (SNAP) account.

Cash Assistance/Employment Support Services

Temporary Assistance for Needy Families (TANF) provides cash assistance to families with dependent children, and pregnant individuals for a limited time. Parents or caretakers, or pregnant individuals who are included in the grant are required to participate in a work program. The Cash Assistance program also provides financial assistance to refugee households who are not eligible for the TANF program.

- Grandparents Raising Grandchildren (GRG) will provide the support necessary so that



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children can be cared for in the homes of their grandparents.

Medical Assistance

Medicaid, for those who are eligible, may help pay medical bills, doctor's visits, and Medicare premiums.

- This includes 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.

Community Outreach Services



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For more information about other DHS services,
please visit our website at
<http://dfcs.georgia.gov> or call (877) 423-4746.

How Do I Apply for Benefits?

Step 1. Fill out the application.

Read the questions carefully and give accurate
information. Sign and date the application.

Step 2. Turn in the application to your local office.

You will need to tear off pages 1-2, 17-20 and
keep them for yourself.

Frequently Asked Questions

How long does it take to get benefits?

Food Stamps (SNAP): up to 30 days

TANF: up to 45 days



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Medicaid: 10 to 60 days

You may be able to get Food Stamps (SNAP) within 7 days if you qualify. See page 6.

How much will I get?

Your income, resources, and family size determine benefit amounts. We will be able to give you specific information once we determine your eligibility.

How will I get my benefits?

For Food Stamps (SNAP), you will get an Electronic Benefit Transfer (EBT) card to access your benefits. For TANF, you will get an EPPIC Debit Master card to access your benefits. For Medicaid, you will receive a Medicaid card for each eligible member.



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You may be asked to provide the following information:

- Proof of identity for the applicant if applying for Food Stamps (SNAP) and/or TANF. An identification card (ID) or driver's license (DL) is an acceptable form of verification. Proof of Identity is not required for Medical Assistance applicants.
- Proof of US citizenship/qualified immigrant status for everyone requesting benefits. If you are applying for Emergency Medical Services (EMA) only, you do not have to provide your SSN or information about your immigration status.
- Social Security numbers of everyone requesting assistance.
- Proof of income for example, pay stubs, child support payments, and income award letters. Proof of child support payments is not needed for Medical Assistance applicants.



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- Proof of expenses like childcare receipts, medical bills, medical transportation costs, rent/mortgage costs, and child support payments. This information is not required for Medical Assistance applicants.

We will first attempt to verify citizenship/immigration status and income information through electronic data sources. Paper verification documents are not required to submit an application; however, you may provide the documents with the application. If we are unable to verify through electronic data sources and you need help getting this information, please tell us.



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Mail, fax, or bring in pages 3-16 of this application to your local Division of Family & Children Services (DFCS) office. You can locate your local office at <http://dfcs.georgia.gov/locations> .

If you or the person for whom you are applying is eligible for benefits, Food Stamp (SNAP) benefits will be provided from the date we receive the application with your name, address, and signature on it. TANF benefits will be provided from the date the application is approved.

If you are applying for Food Stamps (SNAP), TANF and/or Medicaid, you can file an application for benefits with only your name, address, and signature. However, it may help us to process your application quicker if you complete the



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entire form. You may use this form to file a joint application for more than one program or for the Food Stamp (SNAP) program only. Your (SNAP) application will not be denied solely on the basis that your application for another program has been denied. We will make a separate eligibility determination for your Food Stamp (SNAP) application. If you are in an institution and applying for Food Stamps (SNAP) and SSI at the same time, the filing date of your application is the date you are released from the institution.

Step 3. Talk with us.

You may need to complete an interview with a worker. If so, we will give you an appointment. This interview can be completed by phone.



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How do we use the applicant's personal information?

You only have to provide Social Security Numbers (SSN) and citizenship or immigration status for persons who want to apply for benefits. This information will be used to check the income and eligibility verification system (IEVS). We will also match your information against other Federal, state, and local agencies to verify your income and eligibility, to track wage information and participation in work activities. If a household member does not want to give us information about their SSN, citizenship or immigration status, other household members may still receive benefits. If you are applying for emergency medical services only, you do not have to provide your SSN or information about your immigration status.



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Can someone else apply for me?

For Food Stamps (SNAP) and Medicaid, you may ask someone to apply for you.

For TANF, anyone can apply but the parent or caretaker or pregnant individual must be interviewed.

(Complete this application and return it to your LOCAL COUNTY DFCS office.)

What Am I Applying For? (Check all that apply)

☐ **Food Stamps (Supplemental Nutrition Assistance Program (SNAP))**

The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, is a federally funded program that provides monthly benefits to low-income households to help pay for the cost of food. The program also provides



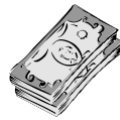
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nutrition education to families to meet their food and nutritional needs and provides employment and training opportunities to help families gain employment that leads to less dependence on SNAP.

☐ **Temporary Assistance for Needy Families (TANF)**

Temporary Assistance for Needy Families (TANF) provides temporary monthly cash payments, single cash payments, or other support services, to strengthen eligible families with children or pregnant individuals. If you are the child's parent, or the caretaker or a pregnant individual who would like to be included in the grant, we will require you to participate in a work program.

☐ **Grandparents Raising Grandchildren (GRG)**



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Grandparents Raising Grandchildren (GRG) will provide additional cash payments so that children can be cared for in the homes of their grandparents. **Applicants must apply for TANF to be eligible for GRG.**

☐ **Refugee Cash Assistance**

The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, Asylees, Afghanis or Iraqis with Special Immigrant Visa (SIV) or eligible Afghan parolees.

☐ **Medicaid**



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Medicaid offers medical coverage to elderly, blind or disabled adults, pregnant women, children, and families. When you apply, we will look at all Medicaid programs and decide which ones you may be eligible to receive.

Please fill out the chart below about the applicant.

First Name _____

Middle Initial _____

Last Name _____

Suffix _____

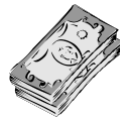
Street Address Where You Live _____

Apt _____

City _____

State _____

Zip Code _____



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Are you homeless? ☐ Yes or ☐ No

Mailing Address (If different) _____

Main Telephone Number _____

Other Contact Number _____

Electronic Communication: _____

Email Address (optional): _____

Email: ☐ Yes or ☐ No (optional)

Texting: ☐ Yes or ☐ No (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):**



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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_____;



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Telephonic signature (if applicable)_____;

Face-to-face interview (home visit)_____;

Other:_____

**Do you need this Reasonable Modification or
Communication Assistance one-
time_____ or ongoing _____?**

**If possible, briefly explain when and how
long you need this modification or
assistance?**

**For All Food Stamp (SNAP), TANF, and
Medicaid Applicants:**

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.



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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 (SNAP) and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of \$4500 or more (before taxes or other amounts are withheld). I will report these



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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 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 Food Stamp (SNAP) benefits.

The Georgia Department of Human Services ("DHS") collects Personally Identifiable Information (PII), such as names, addresses, telephone numbers, email addresses, and dates



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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



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Authorized Representative:

Complete this section only if you want a person or an organization to fill out your application, complete your interview, and/or use your EBT card to buy food when you cannot go to the store. Please check 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 or organization to act on your behalf.

Authorized Representative 1 Program Types:

Food Stamps (SNAP) ☐

TANF ☐

Medical Assistance ☐



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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 (EPPIC) ☐

Person Name 1: _____

Organization Name 1 (if applicable):

Phone: _____

Address: _____

Apt: _____

City: _____

State: _____



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Zip: _____

Electronic Communication:

Email: ☐ Yes ☐ No (optional)

Texting: ☐ Yes ☐ No (optional)

Email Address (optional) _____

Preferred Language: _____

Is an interpreter needed? ☐ Yes ☐ No

Authorized Representative 2 Program Types:

Food Stamps (SNAP) ☐

TANF ☐

Medical Assistance ☐

Authorized Representative 1 Duties:

Sign application on applicant's behalf ☐

Complete and submit renewal form ☐



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Receive copies of notices and other
communication ☐

Act on behalf of applicant in all other matters ☐

Receive a TANF benefit card (EPPIC) ☐

Person Name 2: _____

Organization Name 2 (if applicable):

Phone: _____

Address: _____

Apt: _____

City: _____

State: _____

Zip: _____

Electronic Communication:

Email: ☐ Yes ☐ No (optional)



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Texting: ☐ Yes ☐ No (optional)

Email Address (optional) _____

Preferred Language: _____

Is an interpreter needed? ☐ 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 (If yes, please describe the
Reasonable Modification or Communication
Assistance that you are requesting):

Sign Language interpreter_____;

TTY_____;



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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**



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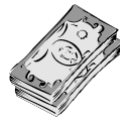
**explain when and how long you need this
modification or
assistance?_____**

For Office Use Only:_____

Date Received: _____

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.



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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



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members make any changes and allow them to opt out of the ELE process or terminate the Medical Assistance case at any time.

Do I Qualify to Get Food Stamps (SNAP) Faster? (This information is required for Food Stamp (SNAP) applicants only)

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

1. Are you or any household member a migrant or seasonal farm worker? ☐ Yes ☐ No

If **yes**, who _____



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2. Total **Gross earned income** that will be
received for this month: \$_____

Employer Name_____

Employment Begin Date_____

Employment End Date _____

Rate of Pay _____

Hours Worked Weekly_____

How Often Are You Paid:

Weekly

bi-weekly

semi-monthly

monthly (circle one)

3. Total **Gross unearned income** that will be
received for this month: \$_____

Type of Unearned Income_____



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Amount_____

How Often Received:

Weekly

bi-weekly

semi-monthly

monthly (circle one)

Type of Unearned Income_____

Amount_____

How Often Received:

Weekly

bi-weekly

semi-monthly

monthly (circle one)

4. Total earned and unearned income for this
month: \$_____



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

\$_____

6. What is the monthly amount of your rent, mortgage, property taxes, and/or homeowner's

\$_____

Insurance?_____

7. What is the total amount of your electric, water, gas, and/or other utilities this month?

\$_____ **(Exclude past due and late fee amounts in the total)**



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a. What is your household's primary heating or cooling source? Mark all that apply.

☐ Electric

☐ Gas

☐ Window or central air conditioner

☐ Kerosene oil

☐ Wood

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

If **yes**, amount received \$_____

Tell Us about the Applicant and All Household Members

For Medical Assistance applicants: Please include yourself, your spouse, your children



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(including stepchildren) under 21 who live with you, your unmarried partner who needs health coverage, anyone you include on your tax return, even if they do not live with you, and anyone else under 21 who you take care of and lives with you. You do not have to include your unmarried partner who does not need health coverage, your unmarried partner's children, your parents who live with you but file their own tax return (if you are over 21), or other adult relatives who file their own tax return. If you are applying for Emergency Medical Services (EMA) only, you do not have to provide your SSN or information about your immigration status.

Please fill out the chart below about the applicant and all household members. The following federal laws and regulations:



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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

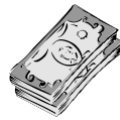
security number (SSN). You will still need to tell

us about **their** income and resources to



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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 (SNAP) claim, the information on this application, including SSN, may be given to Federal and State agencies and private claims



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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.

NAME

First_____

Middle Initial_____

Last_____

Relationship_____

Is this person applying for benefits? SELF

☐ Yes ☐ No

Does this person need health coverage?

☐ Yes ☐ No

Birth Date_____Format (mm/dd/yy)

Social Security Number_____



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(Optional for Non -Applicants)

Sex: ☐ Masculine ☐ Feminine

Hispanic or Latino? (Optional) _____

Race Code (Optional) _____

(See codes Below)

Are you a U.S citizen, U.S. National, qualified
immigrant or in a satisfactory immigration
status? **(Applicants only)** ☐ Yes ☐ No

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



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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.

If you or other household applicants are not U.S. Citizens or U.S. Nationals, complete the following chart: (please add additional pages as needed)

NAME

First_____

Middle Initial_____

Last_____

Immigration document type_____

Alien/Certificate/Document ID number _____



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Have you lived in the U.S. since 1996?

☐ Yes ☐ No

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?

☐ Yes ☐ No

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



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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 FS benefits in more than one area after 8/22/1996? (For SNAP only)

☐ Yes ☐ No

If **yes**:



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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: _____



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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: _____



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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 Food Stamp (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



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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 Food Stamps (SNAP) and TANF only) or a violent felony (For TANF only)? ☐ Yes ☐ No

If **yes**:

Who: _____

When: _____



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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 Food Stamp (SNAP) benefits



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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 Food Stamp (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,



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ammunition, or explosives after 8/22/1996? (For Food Stamps (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**:



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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



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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**:



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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: _____

Tell Us about the Applicant and All Household Members Income

**Do you or anyone who lives in your
household receive any type of income such
as:** wages, tips, bonuses, self-employment,
Social Security/Railroad Retirement, other



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disability, pensions, unemployment, or any other income? For Food Stamps (SNAP) and TANF, please also list income such as: VA income, child support, money from other people or workers compensation. If yes, complete the chart below.

Household Member Name with Income_____

Type of Income_____

Employer Name/Source of Income_____

Monthly Amount (Before Deductions)_____

How Often received (monthly, biweekly,
weekly)_____

Pay Per Hour_____

Hours per Week_____

DATE (S) PAID_____

Is anyone currently on strike? ☐ Yes ☐ No



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If self-employed, please list your monthly business expenses amount: \$_____

Tell Us about the Applicant and All Household Members Resources - For TANF and SNAP applicants, list all resources for all household members and Medicaid applicants who are Aged (65 or older), Blind or Disabled (permanent impairment that prevents you from working)

Do you or anyone you are applying for own any resources? ☐ Yes ☐ No

If **yes**, please complete the information below (Check all resources (assets) owned by you, your spouse, your dependents or jointly owned with someone else. Attach additional pages if necessary).



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Checking Accounts ☐ Yes ☐ No

Funeral Plans/Prepaid Burial Item ☐ Yes ☐ No

Savings Accounts ☐ Yes ☐ No

Burial Plots or Contracts ☐ Yes ☐ No

Government Bonds ☐ Yes ☐ No

Stocks and Bonds ☐ Yes ☐ No

Trust Funds ☐ Yes ☐ No

Other (IRA, CD, etc.) ☐ Yes ☐ No

Real Property/Homeplace Property? ☐ Yes ☐ No

Have you or your spouse given away any assets
for less than its value? ☐ Yes ☐ No

If you answered yes to any of these questions,
please describe below.

Household Member Name with Resource_____



Application for Benefits

Type of Resource_____

Account/Policy Number_____

Value_____

Name of Bank, Insurance Company,
etc._____

Do you or your spouse own a vehicle?

☐ Yes ☐ No

If **yes**, please describe below.

Household Member Name with Resource_____

Vehicle Make _____

Account/Policy Number_____

Model _____

Year_____

Amount Owed_____



Application for Benefits

Do you or your spouse have a life insurance policy? ☐ Yes ☐ No

If **yes**, please complete the following information.

Policy Owner_____

Insurance Company_____

Policy Number_____

Face Value_____

Cash Value_____

Tell Us about the Applicant and All Household Members Expenses (Optional for Medicaid applicants)

Do you pay for the care of a dependent child or a disabled adult household member?

☐ Yes ☐ No



Application for Benefits

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

Person who requires care _____

Person who pays for care _____

Reason for care _____

Provider's Name/Number _____

Amount paid to Provider _____

How often paid _____

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:** _____



Application for Benefits

Does anyone in the household pay child support to someone living outside of the home?

☐ Yes ☐ No

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

Household Member Obligated to

Pay _____

Name of Child for Whom Support is

paid _____

Obligated Amount to Pay _____

Actual Amount Paid _____

To Whom is Child Support Paid? _____

Does anyone 60 years of age or older or disabled have medical expenses?

☐ Yes ☐ No

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



Application for Benefits

Household Member Who Has

Expense_____

Type of Expense (doctor visits, hospital visit,
prescriptions, Medicare or health Insurance
premiums, glasses)_____

Amount Owed_____

Still Owed? ☐ Yes ☐ No

Date Paid_____

Will Insurance Pay? ☐ Yes ☐ No

**Does anyone 60 years of age or older or
disabled have medical expenses for
transportation?**

☐ Yes ☐ No

If **yes**, complete chart below.

Purpose of the trip (doctor or hospital visit;
pharmacy pick-up)_____



Application for Benefits

Total miles driven: _____

Cost of taxi, bus, parking or lodging: _____

**Do you or any household member have
shelter and utility expenses?** ☐ Yes ☐ No

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

- ☐ Expense
- ☐ Rent/Mortgage
- ☐ Property Taxes
- ☐ Property Insurance
- ☐ Electricity
- ☐ Gas
- ☐ Fuel Oil/Wood/Kerosene
- ☐ Well/Septic Tank/Water/Sewage
- ☐ Garbage



Application for Benefits

☐ Telephone

☐ Other

Amount _____

How Often? _____

Who paid? _____

**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's Name _____

Landlord's address: _____



Application for Benefits

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? _____

Please complete the following information if applying for Medicaid.

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR?

☐ Yes ☐ No



Application for Benefits

If **yes**, who? (List each person who plans to file.)

2. Will any of the tax filers listed file jointly with a spouse? ☐ Yes ☐ No

If **yes**, please list spouse's name:

3. Will any of the tax filers claim any dependents on their tax return? ☐ Yes ☐ No

If **yes**, please list name(s) of dependents:

4. Will anyone be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

If **yes**, please list the name of the tax filer and the dependent:



Application for Benefits

(Filer) _____

(Dependent) _____

How is the tax dependent related to the tax filer?

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

☐ Alimony paid \$_____ How often? _____

☐ Student loan interest \$_____ How often? _____

☐ Health Insurance Premiums, 401K, and Other
Pre-Tax Deductions \$_____

How often? _____

☐ Other deductions \$_____

How often? _____ Type: _____



Application for Benefits

Other health coverage

1. Does anyone have other health insurance that covers anyone in your household?

☐ Yes ☐ No

If you answered **yes** to question 4 above, please complete the following information and

Attachment A:

Name of Policy holder_____

Health Insurance Company Name, Address and Telephone Number _____

Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical)_____

Name of Persons Covered_____

Effective Date_____

Policy Number_____



Application for Benefits

2. Is anyone listed on this application offered health coverage from a job? Check **yes** even if the coverage is from someone else's job, such as a parent or spouse. ☐ Yes ☐ No

If **yes**, you need to complete Attachment A.

Is this a state employee benefit plan?

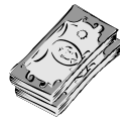
☐ Yes ☐ No

3. Have you or anyone listed on this application lost any health coverage in the last 2 months?

a. ☐ Yes If **yes**, why was it lost?

b. ☐ No

4. Was anyone in Foster Care at age 18 applying for Medicaid? ☐ Yes ☐ No



Application for Benefits

5. Is anyone in your household American or Alaska Native? ☐ Yes ☐ No

If **yes**, complete Attachment B.

If anyone is aged (65 or older), blind or disabled (permanent impairment that prevents you from working), please answer questions. (Optional)

1. Is anyone applying for health coverage blind or disabled? ☐ Yes ☐ No

If **yes**, please list name: _____

2. Are you or your spouse currently covered by Medicare? ☐ Yes ☐ No

If **yes**, please list name: _____



Application for Benefits

3. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?

☐ Yes ☐ No

If **yes**, date of SSI application: _____

4. Are you applying for someone who is now deceased and has unpaid medical bills within the last three (3) months?

☐ Yes ☐ No

5. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?

☐ Yes ☐ No



Application for Benefits

6. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?

☐ Yes ☐ No

7. Are you applying for Medicaid to help pay for community-based waiver services such as Community Care Services, NOW/COMP, Hospice Care, Independent Care Waiver, or the Deeming Waiver (Katie Beckett)?

☐ Yes ☐ No



Application for Benefits

SNAP Penalties

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



Application for Benefits

Any household member who breaks any of the Food Stamp (SNAP) rules on purpose can be barred from the Food Stamp (SNAP) Program for one year to permanently, fined up to \$250,000, imprisoned up to 20 years or both. She/he may also be subject to prosecution under other applicable Federal and State laws. She/he may also be barred from the Food Stamp (SNAP) Program for an additional 18 months if court ordered.

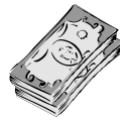
Any household member who intentionally breaks the rules may not get Food Stamps (SNAP) for one year for the first offense, two years for the second offense, and permanently for the third offense.



Application for Benefits

If a court of law finds you or any household member guilty of using or receiving Food Stamp (SNAP) benefits in a transaction involving the sale of a controlled substance, you or that household member will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you or any household member guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives, you or that household member will be permanently ineligible to participate in the Food Stamp (SNAP) Program upon the first offense of this violation.



Application for Benefits

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 (SNAP) 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 (SNAP) benefits, you or that household member will be ineligible to participate in the Food Stamp (SNAP) Program for a period of 10 years.

TANF Program Penalties



Application for Benefits

In the TANF Program, an IPV (Intentional Program Violation) is an intentional action by an individual to establish or maintain an assistance unit's (AU's) eligibility, or to increase or prevent a decrease in the AU's benefits, by providing false or misleading information or withholding information.

- Any household member who hides information and does not report changes on time or does not tell the truth will lose TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation. The misuse of 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



Application for Benefits

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 and will result in a loss of TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation.

- If a court of law finds you or any household member hiding information or you do not report changes on time or do not tell the truth and are convicted, you may not get TANF for 6 months for the first violation, 12 months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member guilty of giving false information about where you live so you can receive benefits in



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more than one state, you will be barred for 10 years.

- If a court convicted you of a drug-related charge, controlled substance, or a serious violent felony on or after 1/1/1997, you or that household member will not be eligible and/or permanently disqualified.

For All SNAP, TANF, and Medicaid Applicants:

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



Application for Benefits

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



Application for Benefits

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



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any such personal information in accordance with
DHS policies, procedures, and as permitted or
required by law and/or regulations.

Applicant's Signature

Date

Authorized Representative's Signature

Date

VOTER REGISTRATION INFORMATION



Application for Benefits

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.



Application for Benefits

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



Application for Benefits

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.



Application for Benefits

**(Keep these documents for your
information)**

What Do the Words Used in this Application Mean?

**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



Application for Benefits

children in his or her care, including an unborn child.

Disqualified

The action taken to remove an individual from a Food Stamp (SNAP) 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 (SNAP). Individuals receiving assistance are issued an EBT debit card, which is used to access their Food Stamp (SNAP) accounts.

Electronic Communications



Application for Benefits

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.



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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;



Application for Benefits

- 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



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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.

Migrant Farm Workers

Individuals who are seasonal farm workers and who move from one home base to another to work or look for farm work.

Non-applicant

An individual who does NOT apply for or receive public assistance/benefits. Non-applicants are



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not required to provide a social security number, citizenship, or immigration status.

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;



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- 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



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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



Application for Benefits

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.

Seasonal Farm Workers

Individuals who work at certain times of the year planting, picking, or packing produce. They are hired on a temporary basis when a job requires more workers than the farm employs on a regular basis.

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



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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



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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



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funds because the funds are electronically loaded to the Debit MasterCard.

For All Medicaid Applicants:

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>.



Application for Benefits

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



Application for Benefits

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



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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



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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->



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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.



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*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.

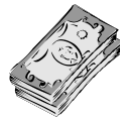


Application for Benefits

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



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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



Application for Benefits

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



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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



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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.

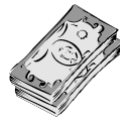
To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at <https://ocrportal.hhs.gov/ocr/>. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of



Application for Benefits

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.



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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**