

**Georgia Department of Human Services**  
**FOOD STAMP (SNAP)/MEDICAID/TANF Renewal**  
**Form**

**If you need help reading or completing this document or need help communicating with us, ask us or call (877) 423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).**

<b><i>For Office Use only:</i></b> Date _____	Client ID # _____ Date Initiated _____
Received _____	
Programs Initiated: <input type="checkbox"/> TANF <input type="checkbox"/> Food Stamps (SNAP) <input type="checkbox"/> Medicaid	

If you are reapplying for Food Stamps (SNAP) or renewing your TANF or Medicaid benefits, you can file this renewal/application form with only your name, address, and signature. **However, it will help us to process your application, recertification/renewal more quickly if you complete the entire form and provide verification of information, if it is**

**requested.** You may use this form to file a joint renewal/application for the Food Stamp (SNAP) /Medicaid and/or TANF program or for the Food Stamp (SNAP) Program only. Your Food Stamp (SNAP) renewal will not be terminated solely on the basis that your renewal/application for another program has been denied/terminated. We will make a separate eligibility determination for your Food Stamp (SNAP) renewal.

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

Client Name:	Date of Birth:	Social Security Number: (Optional for Non-Applicants*)
		*See Citizenship Immigration Status & Social Security Numbers below.
Street Address:		
Mailing Address:		

Main Phone Number:	Other Contact Number:
Electronic Communication: Email: Yes ___ or No __ (optional) Texting: Yes . or No __ (optional)	Email Address: (optional)
What is your Preferred Language?	If an interview is required, will you need an interpreter? Yes_or No .

**Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):**

**Do you have a disability that will require a Reasonable Modification or Communication Assistance? Yes \_\_\_\_\_ No**

---

**(If yes, please describe the reasonable modification or Communication Assistance that you are requesting):**

Sign Language interpreter\_\_\_\_\_; TTY\_\_\_\_\_; Large Print\_\_\_\_;  
Electronic communication (email)\_\_\_\_\_; Braille\_\_\_\_; Video Relay  
\_\_\_\_; Cued Speech Interpreter\_\_\_\_; Oral Interpreter\_\_\_\_; Tactile  
Interpreter\_\_\_\_; Telephone call reminder of program deadlines\_\_\_\_  
; Telephonic signature (if applicable)\_\_\_\_ ; Face-to-face  
interview (home visit)\_ ; Other:\_\_\_\_\_

**Do you need this Reasonable Modification or  
Communication Assistance one-time\_\_\_\_\_or ongoing  
\_\_\_\_\_? If possible,  
briefly explain when and how long you need this  
modification or assistance?**

I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are noncitizen(s) lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge. I understand and agree that DHS-DFCS, DCH and authorized Federal Agencies may verify the information I give on this application. Information may be obtained from past or present employers. I understand that my information will be used to track wage information and my participation in work activities.

I will report any change in my situation according to 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 \$4250 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 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 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

---

### **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) or Temporary Assistance for Needy Families (TANF) into the Medical Assistance program. If your children are eligible for SNAP or TANF, the Division of Family and Children Services (DFCS) will use the household size, residency, and income information from SNAP or TANF, but DFCS will verify citizenship or immigration status using Medical Assistance rules to make an ELE determination to enroll or renew the children in Medicaid or PeachCare for Kids®. If your children are eligible for PeachCare for Kids®, they may be subject to a premium. DFCS will send you a determination notice, let you make any changes and allow you to opt out at any time.

Do you agree to allow DFCS to use your information from SNAP or TANF to make an ELE determination to enroll or renew your children in Medicaid or PeachCare for Kids®?

Yes    No

## Authorized Representative:

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

Authorized Representative 1 Program Types: Food Stamps (SNAP)

TANF  Medical Assistance

Authorized Representative 1 Duties: Sign application on applicant's behalf  Complete and submit renewal form

Receive copies of notices and other communication  Act on behalf of applicant in all other matters

Receive a TANF benefit card (EPPIC)



Person Name 1: \_\_\_\_\_

Organization Name 1 (if applicable): \_\_\_\_\_ Pho \_\_\_\_\_  
ne: \_\_\_\_\_

Address: \_\_\_\_\_ Apt \_\_\_\_\_  
:

City: \_\_\_\_\_ Stat \_\_\_\_\_ Zip: \_\_\_\_\_  
e: \_\_\_\_\_

Electronic Communication: Email: Yes \_\_\_\_\_ No \_\_\_\_\_  
\_\_\_\_\_ No \_\_\_\_\_ (optional)

(optional)

Email Address (optional) \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Is an interpreter needed?  
Yes \_\_\_\_\_ or No \_\_\_\_\_

Authorized Representative 2 Program Types: Food Stamps (SNAP)

TANF  Medical Assistance

Authorized Representative 2 Duties: Sign application on applicant's  
behalf  Complete and submit renewal form

Receive copies of notices and other communication  Act on behalf  
of applicant in all other matters

Receive a TANF benefit card (EPPIC)

Person Name 2: \_\_\_\_\_

Organization Name 2 (if applicable): \_ Pho \_\_\_\_\_

ne:

Address: \_\_\_\_\_ Apt \_\_\_\_\_

:

City: \_\_\_\_\_ Stat \_\_\_\_ Zip:

e: \_\_\_\_\_

Electronic Communication: Email: Yes Texting: Yes\_\_No

\_\_\_\_\_ No \_ \_\_\_\_\_(optional)

(optional)

Email Address (optional) \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Is an interpreter needed?

Yes\_\_\_\_\_or No\_

**Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance for Authorized Representatives (if applicable):**

**Does the authorized representative have a disability that will require a Reasonable Modification or Communication**

**Assistance? Yes/No\_(If yes, please describe the reasonable modification or Communication Assistance that you are requesting):**

Sign Language interpreter\_\_\_\_; TTY\_\_\_\_; Large Print\_\_\_\_;  
Electronic communication (email)\_\_\_\_; Braille\_\_\_\_; Video Relay  
\_\_\_\_; Cued Speech Interpreter\_\_\_\_; Oral Interpreter\_\_\_\_; Tactile  
Interpreter\_\_\_\_; Telephone call reminder of program deadlines\_\_\_\_  
; Telephonic signature (if applicable)\_\_\_\_ ; Face-to-face  
interview (home visit)\_ ; Other:\_\_\_\_\_

**Does the authorized representative need this Reasonable Modification or Communication Assistance one-time\_\_\_\_\_or ongoing**

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

**For Medicaid only:**

**Do you expect to file a federal income tax return NEXT YEAR?** (You can still apply for health insurance even if you don't file a federal income tax return.)

Yes  No If **yes**, please answer questions a, b, and c. If No, please answer question c.

a. Will you file jointly with a spouse?

Yes  No If **yes**, name of spouse:\_\_\_\_\_

b. Will you claim any dependents on your tax return?  Yes  No

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

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

If **yes**, list the name of the tax filer and the tax dependents:\_\_\_\_\_

How is the tax dependent related to the tax filer?\_\_\_\_\_

## **COMMUNITY OUTREACH SERVICES:**

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

## **CITIZENSHIP IMMIGRATION STATUS AND SOCIAL SECURITY NUMBERS:**

**Please fill out the chart below about the applicant and all household members. The following federal laws and regulations: The Food and Nutrition Act of 2008, 7 U.S.C. § 2011 -2036, 7. C.F.R. § 273.2, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, authorize DFCS to request you and your household members Social Security number(s).** Anyone who is living in your household and is not applying for benefits may be treated as a **non- applicant**. Non-applicants do not have to give us information about their Social Security number, citizenship, or immigration status and are not eligible for benefits. Other household members may still be able to receive benefits if they are otherwise eligible. If you want us to decide whether any household members are eligible

for benefits, you will still need to tell us about their citizenship or immigration status and give us their Social Security number (SSN). You will still need to tell us about **their** income and resources to determine the eligibility and benefit level of the household. We will not report any non-applicant household members to the United States Citizenship and Immigration Services (USCIS) Systematic Alien Verification for Entitlements (SAVE) system if they do not give us their citizenship or immigration status. However, if immigration status information has been submitted on your application, this information may be subject to verification through the SAVE system and may affect the household's eligibility and benefit level. We will match your information with other Federal, state, and local agencies to verify your income and eligibility. This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a Food Stamp (SNAP) claim, the information on this application, including SSN, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim. We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status. If you are applying for emergency medical

services only, you do not have to provide your SSN or information about your immigration status.

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

**Race Codes** (Choose all that apply):

**AI** - American Indian or Alaska Native

**AS** - Asian

**BL** - Black or African American

**HP** - Native Hawaiian or Other Pacific Islander

**WH** - White

By providing Race/Ethnicity information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information, and it will not affect your eligibility or benefit level. However, if you do not provide this information, visual identification of race and ethnicity will be made during the first face-to-face interview.

**If you or other household applicants are a Naturalized Citizen, or a qualified alien/immigrant complete the following chart:**

(please add additional pages as needed)

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

**For Medicaid only:**

**Was anyone in your household in Foster Care at age 18?**

Yes  No

**If you have tax dependents that do not live in the home with you, please list below.**

Name: \_\_\_\_\_ Social Security Number\_ Sex: M F (please circle one)

Date of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_



Relationship to you: \_\_\_\_\_(please add additional pages as needed)

## **Tell Us More about the Applicant and All Household Members**

We need more information about the applicant and all household members in order to decide who is eligible for benefits.

Please answer only the questions about the benefits you want to receive on the page below.

1. Has anyone received any benefits in another county or state?  
(For Food Stamps (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 Food Stamps (SNAP) only)  Yes

No

If **yes**:

Who: \_\_\_\_\_

Where: \_\_\_\_\_

When: \_\_\_\_\_

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

If **yes**, 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**, what was the delivery/termination date?\_\_\_\_; and how many babies were delivered/expected?\_\_\_\_\_

Name of pregnant woman:\_\_\_ Unborn baby's father's name: \_

Father's address:\_\_\_\_\_

5. For Medicaid applicants, does anyone have any unpaid medical bills for the last 3 months? Yes  No

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

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

If **yes**:

Who: \_\_\_\_\_

Where: \_\_\_\_\_

7. Is anyone fleeing to avoid prosecution or jail for a felony? (For Food Stamps (SNAP) and TANF only)  Yes  No

If **yes**, who: \_\_\_\_\_

8. Is anyone violating conditions of probation or parole? (For Food Stamps (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: \_\_\_\_\_

a. Are you in compliance with the terms of probation related to any sentence received as a result of a drug felony conviction? (For Food Stamps (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 Food Stamps (SNAP) only)

Yes  No

c. Have you successfully completed **all the terms of probation or parole** related to any drug related conviction? (For Food Stamps (SNAP) only)

Yes  No

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

If **yes:**

Who: \_\_\_\_\_

When: \_\_\_\_\_

12. Have you or any household member been convicted of trading Food Stamp (SNAP) benefits for guns, 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 Food Stamps (SNAP) only)       Yes  No

If **yes:**

Who: \_\_\_\_\_

When: \_\_\_\_\_

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

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

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

If **yes:**

Who: \_\_\_\_\_ When: \_\_\_\_\_ Amount  
Received: \_\_\_\_\_

15. Has anyone used TANF funds or the EPPIC Card at the following establishments, liquor stores, casinos, poker rooms, adult entertainment business, bail bonds, night clubs, salons/taverns, bingo halls, racetracks, gun/ammunition stores,



cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons?

(For TANF only)       Yes  No

If **yes:**

Who: \_\_\_\_\_ When: \_\_\_\_\_

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

If **yes:**

Who: \_\_\_\_\_

Monthly Amount Received: \_\_\_\_

Date alimony agreement finalized or last modified: \_\_

**For Food Stamps (SNAP) and TANF only:**

**STUDENTS IN HIGHER EDUCATION: Is anyone in your household enrolled at least half-time in a college, university, vocational or technical school?**

Yes  No

If **yes,** who: \_\_\_\_\_

School Name: \_\_\_\_\_ Grade/Status

\_\_\_\_\_ Graduation date: \_\_\_\_\_

Is the student employed?  Yes  No Enrolled in work study?

Yes  No

If **yes**, hours worked per week\_ (Please complete the employment section below as well.)

**For Food Stamps (SNAP) only:**

**Does anyone age 60 or older or disabled have medical expenses?  Yes  No**

Did your medical expenses such as Medicare premiums, prescription drug cost, or hospital bills change?

Yes  No

**If yes, list expenses on 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 \_\_ Policy Number \_\_\_\_

Other: Name of Insurance \_\_\_\_\_ Policy Number \_

Do you have any health insurance **other than** Medicaid?

Yes  No

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

## RESOURCES:

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

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

Resource Type	Owner	Account/Policy # (Do not complete If your account/policy # is the same as your SSN)	Value	Name of Bank, Insurance Company etc.
Cash				
Checking/Savings				
Credit Union				
Annuities				
Stocks or Bonds				
Safe Deposit Box				
Retirement Account (For non-MAGI 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? \_\_\_\_\_

**For Food Stamps (SNAP), TANF, and Medicaid:**

**EMPLOYMENT: Does anyone in your household work?**

**Yes**  **No**

**If yes, list information of the employed person’s pay from employment such as wages, bonus, and tips, and attach proof of ALL gross income received in the last 4 weeks.**

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

**For Medicaid only:**

**PRE-TAX EXPENSES:**

Health Insurance \$\_\_\_\_\_How often?\_\_\_\_\_  Vision

Insurance \$\_\_\_\_How often?\_\_\_\_

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:**

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?\_\_\_\_\_  Other

Deduction Type \$\_\_How often?\_

**For Food Stamps (SNAP), TANF, and Medicaid:**

**Has anyone stopped working?  Yes  No If yes,**

**complete the following and provide proof:**

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



**Has anyone stopped 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): <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> 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

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.

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 (SNAP) 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, Sexual Harassment, Sexual Assault, or Stalking?

Yes  No

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

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

**Auto Expense:**

Are you the parent or a relative of the child (or children) and are you included in the TANF AU with the child (or with the children)?

Yes  No

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

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

If **yes**, who? (Name of owner)\_\_\_\_\_

\_\_\_\_\_

Year, Make and Model of the vehicle:\_\_\_\_\_

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

\_\_\_\_\_

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

If **yes**, please list:\_\_\_\_\_



## **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**

## **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 (SNAP), your case may be denied or closed.
- (for Food Stamps (SNAP)) cooperating with Quality Control reviewers when they call or come to your home to interview you about the information you have given your case manager.

If you do not cooperate with them, your case may be denied or closed.

- (for Food Stamps (SNAP) and TANF) repaying benefits you should not have received.
- (for Medicaid) cooperating with Medicaid Eligibility Quality Control or Program Integrity when they call or come to your home to interview you about the information you have given your case manager.
- (for Medicaid) members who are in a Nursing Home, Intermediate Care Facility, Community-Based Service, or are enrolled in and receive services through a waiver program, cooperating with Estate Recovery.

If you receive **Food Stamps (SNAP)**, 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 \$4250 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 (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).

**Anyone in your household who breaks any of these rules on purpose can be barred from the Food Stamp (SNAP) 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 (SNAP) for one year for the first offense, two years for the second offense, and permanently for the third offense.**

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

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

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

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

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



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

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

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

**Examples of participant fraud and abuse are:**

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

To report suspected Medicaid fraud on recipients or providers, call the Georgia Department of Community Health-Office of Inspector

General at (local) (404) 463-7590 or (toll free) (800) 533-0686; by email at [oisanonymous@dch.ga.gov](mailto:oisanonymous@dch.ga.gov); by mail at Department of Community Health, OIG PI Section, 2 Peachtree Street NW, 5<sup>th</sup> Floor, Atlanta, GA 30303; or visit <https://dch.georgia.gov/report-medicaidpeachcare-kids-fraud>.

## **VOTER REGISTRATION INFORMATION**

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Yes

No

I do not want to answer the Voter Registration question

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

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

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

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

**A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration application from your caseworker. If you complete a Voter**

**Registration application, submit it to the Georgia Secretary of State's Office following the instructions provided on the Voter Registration application.**

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

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

**For Medicaid only - sign here when the**

**Applicant/Member/Legal Guardian is completing:**

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

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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

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

\_\_\_\_\_

(Signature)

\_\_\_\_\_

(Date)

**Phone where you can be reached** \_\_\_\_\_

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

\_\_\_\_\_

(Applicant/Member/Parent/Legal Guardian)

\_\_\_\_\_

(Date)

**For Food Stamps (SNAP) and/or TANF - when the Applicant/Recipient/Legal Guardian is completing:**

I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are

U.S. citizen(s) or are noncitizen(s) lawfully present in the United States. I further certify that all 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 \$4250 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 during my



application or renewal process and/or fail to verify them, DHS-DFCS will not budget that expense in calculating the amount of my SNAP benefits.

The Georgia Department of Human Services (“DHS”) collects Personally Identifiable Information (PII), such as names, addresses, telephone numbers, email addresses, and dates of birth, etc., during your application for benefits. By submitting any personal information to us, you agree that we may collect, use, and disclose any such personal information in accordance with DHS policies, procedures, and as permitted or required by law and/or regulations.

---

(Signature)

---

(Date)

# (Keep these documents for your information)

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

<b>Applicant</b>	An individual who applies to receive public assistance or benefits.
<b>Assistance Unit (AU)</b>	An assistance unit includes <i>eligible</i> individuals who live together and receive public assistance/benefits.
<b>Caretaker</b>	A parent, relative or legal guardian who applies for and receives TANF with children in his or her care.
<b>Client ID</b>	A unique number assigned to an individual receiving public assistance/benefits.
<b>Disqualified</b>	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.
<b>Domestic Violence</b>	Domestic violence can include being hit, kicked, beaten, raped, choked, threatened, controlled, or kept from getting what you need to live (such as food, medicine, or

	a home) by a spouse, boyfriend/girlfriend,, partner, or "ex".
<b>Electronic Benefit Transfer (EBT)</b>	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.
<b>Electronic Communications</b>	<p>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.</p> <p>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 <a href="http://www.gateway.ga.gov">www.gateway.ga.gov</a> to update your notification settings.</p> <p>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.</p>

<p><b>EPPICard debit MasterCard</b></p>	<p>The State of Georgia has implemented a convenient “electronic” payment option for the TANF recipients called the EPPICard debit MasterCard. Under this payment option, money is deposited in the recipient’s account on the first calendar day of the month. If the first falls on a weekend or holiday, benefits are made available on the last business day of the prior month. The recipient has immediate access to his or her funds because the funds are electronically loaded to the debit MasterCard.</p>
<p><b>Grantee Relative</b></p>	<p>A parent, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children.</p>
<p><b>Gross Income</b></p>	<p>A person’s total income before taking taxes or other deductions into account.</p>
<p><b>Household Members</b></p>	<p>Individuals who live in your home. For Food Stamps (SNAP), individuals who live together and purchase and prepare their meals together.</p>
<p><b>Income</b></p>	<p>Payments such as wages, salaries, commissions, bonuses, worker’s compensation, disability, pension, retirement benefits, interest, child support or any other form of money received.</p>

<p><b>Middle Class Tax Relief Act of 2012</b></p>	<p>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.</p>
<p><b>Non-applicant</b></p>	<p>An individual who does NOT apply for or receive public assistance/benefits. Non-applicants are not required to provide a social security number, citizenship, or immigration status.</p>
<p><b>Payee</b></p>	<p>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.</p>
<p><b>Pre-Tax Expenses</b></p>	<p>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</p>

	insurance, dental insurance, vision insurance, etc.
--	---

<http://www.irs.gov>

**Qualified****Alien/Immigrant**

A *qualified alien/immigrant* is a person who is legally residing in the U.S. who falls within one of the following categories:

- a person *lawfully admitted for permanent residence* (LPR) under the Immigration and Nationality Act (INA);
- *Amerasian* immigrant under section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988;
- A person who is *granted asylum* under section 208 of the INA;
- *Refugees*, admitted under section 207 of the INA;
- A person *paroled* as a refugee or asylee under section 212 (d)(5) of the INA;
- A person whose *deportation* is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or section 241(b)(3) of the INA, as amended;
- A person who is *granted conditional entry* under section 203(a)(7) of the INA as in effect prior to April 1, 1980;
- *Cuban or Haitian* immigrants as defined in section 501 (e) of the Refugee Education Assistance Act of 1980;

- *Victims of human trafficking* under section 107(b)(1) of the Trafficking Victims Protection Act of 2000;
- *Battered immigrants* who meet the conditions set forth in section 431 (c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended;
- *Afghan or Iraqi* immigrants granted special immigrant status under section 101(a)(27) of the INA (subject to specified conditions);
- *American Indians* born in Canada living in the U.S. under section 289 of the INA or non-citizens of federally-recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and;
- *Hmong or Highland Laotian tribal members* that rendered assistance to U.S. personnel by taking part in military or rescue operation during Vietnam Era (8/05/1964 - 5/07/1975).

For Medical Assistance applicants only, Compact of Free Association (COFA) are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands and the



	Republic of Palau. COFA migrants do not have to meet the 5-year bar.
<b>Resources</b>	Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance.
<b>Sexual Assault</b>	Nonconsensual sexual act proscribed by Federal, Tribal, or State law, including when the victim lacks capacity to consent.
<b>Sexual Harassment</b>	Hostile, intimidating, or oppressive behavior based on sex that creates an offensive work environment.
<b>Stalking</b>	The act or crime of willfully and repeatedly following or harassing another person in circumstances that would cause a reasonable person to fear injury or death especially because of express or implied threats.
<b>Taxable Income</b>	Payments such as wages, salaries, commissions, bonuses, disability, pension, retirement benefits, interest, or any other form of money received.
<b>Tax Dependent</b>	An individual who expects to be claimed on a tax filer's tax return. <a href="http://www.irs.gov">http://www.irs.gov</a>
<b>Tax Filer</b>	An individual who expects to file a tax return. <a href="http://www.irs.gov">http://www.irs.gov</a>

<p><b>Tax Return Deductions</b></p>	<p>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.</p> <p><a href="http://www.irs.gov">http://www.irs.gov</a></p>
<p><b>Trafficking in the Food Stamp (SNAP) Program</b></p>	<p><i>Trafficking</i> SNAP benefits means:</p> <p>(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</p>

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 the DCH Katie Beckett (KB) Team at (678) 248-7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at <https://dfcs.georgia.gov/adasection-504-and-civil-rights>, or you may obtain the DCH ADA Reasonable Modification Request Form from the KB Team 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 47 Trinity Avenue SW, 1<sup>st</sup> Floor, Atlanta, GA 30334, (404) 657-3735. For DCH, contact the KB Team ADA/Section 504 Coordinator at 2211 Beaver Run Road, Ste. 150, Norcross, GA 30071, or PO Box 172, Norcross, GA 30091, (678) 2487449. The DCH email is: [dch.adarequests@dch.ga.gov](mailto:dch.adarequests@dch.ga.gov).

You can ask your case worker for a copy of the DFCS Civil Rights, ADA/Section 504 complaint form. The complaint form is also available at <https://dfcs.georgia.gov/adasection-504-and-civil-rights>. If you need help making a discrimination complaint, you may contact the DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us. The email for DCH Civil Rights complaints is: [dch.civilrights@dch.ga.gov](mailto:dch.civilrights@dch.ga.gov). The link for the DCH Civil Rights process and complaint form is located at <https://dch.georgia.gov/adasection-504-and-civil-rights>.

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

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

Under the **Department of Community Health (DCH)** policy, the Medical Assistance programs cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or religion.

## **Do Not Send Applications to the USDA or HHS**

### **Nondiscrimination Statement**

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

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



deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 8778339. Additionally, program information may be made available in languages other than English.

## **CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS**

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at

<https://www.usda.gov/sites/default/files/documents/USDA-OASCRP-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>,

and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **mail:** Food and Nutrition Service, USDA

1320 Braddock Place, Room 334, Alexandria, VA 22314; or

2. **fax:** (833) 256-1665 or (202) 690-7442; or

3. **phone:** (833) 620-1071; or

4. **email:** [FNSCIVILRIGHTSCOMPLAINTS@usda.gov](mailto:FNSCIVILRIGHTSCOMPLAINTS@usda.gov).

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

## **CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS**

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

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

This institution is an equal opportunity provider.

Under the Department of Human Services (DHS), you may also file other discrimination complaints by contacting your local DFCS

office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 47 Trinity Avenue SW, 1st Floor, Atlanta, GA 30334, (404) 6573735. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 47 Trinity Avenue SW, 1st Floor, Atlanta, GA 30334, or call (404) 657-5244.

**Do Not Send Applications to the USDA or HHS**