Division of Family and Children Services

Georgia Senior Supplemental Nutrition Assistance Program (SNAP) Application

This application is used for individuals applying for the Supplemental Nutrition Assistance Program (SNAP) *formerly the Food Stamp Program)*. The Georgia Senior SNAP program is an elderly simplified application project designed to make it easier for seniors to receive food stamp benefits.

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

- 60 years of age or older;
- must purchase and prepare their meals together;
  AND
- have no earnings from work.

You may file this application by completing your name and address, and by signing this form. If you need help reading or completing this document or need help communicating with us, ask us or call 1-877-423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay). If you are living 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.

Can I Choose Someone to Apply for SNAP for me?

Complete this section only if you want someone to fill out your application for you as your authorized representative.

Name: _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____

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

First Name	*Middle Initial*	*Last Name*	*Suffix*
Street Address Where You Live			*Apt*
City		*State*	*Zip Code*
Mailing Address (if different)			
City		*State*	*Zip Code*
Home Telephone Number	*Other Contact Number*		*E-Mail address*
For Office Use Only		Date Received By The County	

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Do I Qualify to Get SNAP Benefits Faster?

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

Did anyone in your household get money this month? ❑ Yes ❑ No If yes, how much?_____When? ___

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

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

$ _____

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

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

***** Penalty Warning:** Individuals who are applying for Food Stamps must provide or apply for an SSN as required by the Food and Nutrition Act of 2008. We will verify and use your SSN for Federal and State data matches, including but not limited to, Social Security, VA, GA Department of Labor, program disqualifications, and for collection of fraud debts. We will also match your information with other Federal, state, and local agencies to verify your income and eligibility. Collateral contacts will be used to verify information when discrepancies are found. If immigration status information has been submitted on your application, this information may be subject to verification through the United States Citizenship and Immigration Service (USCIS) and will require submission of certain information from this application to USCIS.
***** Optional:** We collect data on race color, and national origin to ensure we are in compliance with Federal civil rights laws. By providing this information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information and it will not affect your eligibility or benefit level. **Choose one or more race codes**: **AL**-American Indian/Alaska Native; **AS**-Asian; **BL**-Black; or African American; **HP**-Hawaiian or other Pacific Islander; **WH**-White.

Tell us more about the applicant and all household members

1) Has anyone been convicted of a drug-related felony that was committed after 8/22/96? Yes ❑ No ❑

If yes, name of person: _____

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

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

c) Have you successfully completed all the terms of probation or parole related to any drug related conviction?

(For Food Stamps Only) ❑Yes ❑ No

2) Is anyone in your household currently serving a Food stamp disqualification due to fraud? Yes ❑ No ❑

If yes, name of person: _____

3) Has anyone been convicted of giving false information about where they live and who they are to get multiple food stamp benefits in more than one area after 8/22/96? Yes ❑ No ❑

If yes, name of person:_____when:_____where:_____

4) Is anyone trying to avoid prosecution or jail for a felony? Yes ❑ No ❑

If yes, who: _____

5) Is anyone violating conditions of probation or parole? Yes ❑ No ❑

If yes, who: _____

6) Have you or any household member been convicted of trading Food Stamp benefits for drugs after 8/22/96? Yes ❑ No ❑

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

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

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

If yes:
Who:_____
When: _____
Amount received: _____

Tell us about the income your household receives

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

Yes ☐ No ☐ **If yes, complete the chart below.**

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

Tell us about your shelter and utility expenses

	YES	NO	If YES, list monthly/yearly amount
Does your household pay mortgage?			
Does your household pay rent?			
Does your household pay property taxes on the home?			
Does your household pay homeowner's insurance?			**If YES, list monthly/yearly amount**
Does your household pay for heating or cooling costs?			
If your household does not pay heating or cooling costs, do you pay other utilities?			**If YES, list the utility costs you pay and the amount you pay below.**

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Tell us about your medical expenses

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

Do you pay a Medicare Premium? Yes ❑ No ❑

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

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

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

For more information about TANF Community Outreach Services, please call 1-877-423-4746 or visit our website at: http://www.dfcs.dhr.georgia.gov.

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

I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge. 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 (Food Stamp) program requirements. I will also report If anyone in my household receives lottery or gambling winnings, gross amount of $3500 or more (before taxes or other amounts are withheld). I will report these winnings within 10 days of the end of the month in which my household receives the winnings. I understand if any information is incorrect, my benefits may be reduced or denied, and I may be subject to criminal prosecution or disqualified from DHS-DFCS programs for knowingly providing incorrect information. I understand that I can be prosecuted if I provide false information or hide information. I understand that if I fail to tell DHS-DFCS about some of my expenses at my application or renewal interview and/or fail to verify them that DHS-DFCS will not budget that expense in calculating the amount of my food stamp benefits.

_____ _____ _____
Signature of Applicant Date Signature of witness if signed by mark

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

SNAP PENALTY WARNINGS

You may lose your benefits or be subject to criminal prosecution for knowingly providing false information.

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

Any household member who breaks any of the Senior SNAP (food stamp program) rules on purpose can be barred from the Food Stamp 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 Program for an additional 18 months if court ordered.

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

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

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

If a court of law finds you or any household member guilty of having trafficked benefits for an aggregate amount of $500 or more, you or that household member will be permanently ineligible to participate in the Food Stamp Program upon the first offense of this violation.

If you or any household member is found to have given a fraudulent statement or representation with respect to identity (who they are) or place of residence (where they live) in order to receive multiple Food Stamp benefits, you or that household member will be ineligible to participate in the Food Stamp Program for a period of 10 years.

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(Keep this document for your information)

Notice of ADA/Section 504 Rights

Help for People with Disabilities

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

How to Request a Reasonable Modification or Communication Assistance

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

How to File a Complaint

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

You can ask your case worker for a copy of the DFCS civil rights complaint form. The complaint form is also available at https://dhs.georgia.gov/documents/dfcs-discrimination-complaint-form-0. If you need help making a discrimination complaint,

you may contact the DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us.

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

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

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

Under the **Department of Community Health (DCH)** policy, the Medical Assistance programs cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs.
To report Medicaid eligibility or provider discrimination, call the Georgia Department of Community Health's Office of Program Integrity **(local 404-463-7590) or (toll free) 800-533-0686**. You may also report suspected Medicaid fraud by calling (toll free) 1-800-533-0686.

NONDISCRIMINATION STATEMENT

In accordance with Federal civil rights law 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, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

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

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

This institution is an equal opportunity provider.