GEORGIADEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# Application for Health Coverage & Help Paying Costs

Form Approved
OMB No. 0938-1191

THINGS TO CONSIDER

## Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premium for health coverage.
- Free or low-cost insurance from **Medical Assistance**.

**You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).**

## Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Attachment C.
- 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, you need to complete this application and Attachment D.

## Apply faster online

Apply faster online at **gateway.ga.gov.**

## What you may need to apply

- Social Security Numbers (or document numbers for any eligible immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

## Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

## What happens next?

Send your complete, signed application to the address on page 8.

**If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit gateway.ga.gov or call **1-877-423-4746**. Filling out this application doesn't mean you have to buy health coverage.

## Get help with this application

- **Online:** gateway.ga.gov
- **Phone:** Call our Help Center at **1-877-423-4746.**
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-877-423-4746** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-877-423-4746.**

**NEED HELP WITH YOUR APPLICATION?** Visit gateway.ga.gov or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

# STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

| 2. Home address (Leave blank if you don't have one.) | | | 3. Apartment or suite number |
|---|---|---|---|
| 4. City | 5. State | 6. ZIP code | 7. County |
| 8. Mailing address (if different from home address) | | | 9. Apartment or suite number |
| 10. City | 11. State | 12. ZIP code | 13. County |

| 14. Phone number | 15. Other phone number |
|---|---|
| (  )  – | (  )  – |

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)? _____

a. Do you need an interpreter? ☐ Yes ☐ No

*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.

# STEP 2 Tell us about your family.

**Who do you need to include on this application?**

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

**DO Include:**

- Yourself
- Your spouse
- Your children under 21 who live with you (including stepchildren)
- Your unmarried partner who needs health coverage if you have shared children and at least one child is applying for coverage
- Anyone you include on your tax return, even if they don't live with you

**You DON'T have to include:**

- Your unmarried partner who doesn't need health coverage if you do not have any shared children
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

**Complete Step 2 for each person in your family.** Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

# STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

**We need this if you want health coverage and have an SSN.** Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-255-0135.

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

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
**If yes,** name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
**If yes,** list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
**If yes,** please list the name of the tax filer: _____
How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No If yes, what is the estimated due date / / ; and how many babies are expected? _____

If no, did you 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? _____

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. Are you **naturalized** or **derived citizen**? *(This usually means you were born outside of the U.S.)* ☐ Yes ☐ No
If Yes, please provide your Alien number and Certificate number. Alien number _____ Certificate number _____

12. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ Yes. Fill in your Immigration document type and Alien/Certificate number below.
a. Immigration document type _____ b. Alien/Certificate number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

15. Are you a full-time student? ☐ Yes ☐ No

16. Were you in foster care at age 18 or older? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

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# STEP 2: PERSON 1 (Continue with yourself)

## Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 19.

☐ **Not employed**
Skip to question 29.

☐ **Self-employed**
Skip to question 28

### CURRENT JOB 1:

19. Employer name and address

20. Employer phone number
( ) –

21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

22. Average hours worked each WEEK

### CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

23. Employer name and address

24. Employer phone number
( ) –

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

26. Average hours worked each WEEK

27. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ Start working more hours ☐ None of these

28. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

29. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ How often?

☐ Pensions $ How often?

☐ Social Security $ How often?

☐ Retirement accounts $ How often?

☐ Alimony received $ How often?

☐ Net farming/fishing $ How often?

☐ Net rental/royalty $ How often?

☐ Other income $ How often?

Type: _____

Date Divorce/Separation was finalized or last modified: ___/___/____

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

**NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid $ How often? Date Divorce/Separation was finalized or last modified: ___/___/____

☐ Student loan interest $ How often?

☐ Health Insurance premiums, 401K, and Other Pre-Tax deductions $ Type: How often?

☐ Other deduction $ Type: How often

31. **YEARLY INCOME:** **Complete only if your income changes from month to month.**

**If you don't expect changes to your monthly income, skip to the next person.**

| Your total income **this year** | Your total income **next** year (if you think it will be different) |
|---|---|
| **$** | **$** |

## THANKS! This is all we need to know about you.

**NEED HELP WITH YOUR APPLICATION?** Visit gateway.ga.gov or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

# STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐Male ☐Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
**We need this if you want health coverage and have an SSN.**

6. Does PERSON 2 live at the same address as you? ☐Yes ☐No
**If no,** list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐Yes ☐No
**If yes,** name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐Yes ☐No
**If yes,** list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐Yes ☐No
**If yes,** please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐Yes ☐No If yes, what is the estimated due date / / ; and how many babies are expected? _____
If no, did PERSON 2 deliver or was a pregnancy terminated within the last 12 months? ☐Yes ☐No
If yes, what was the delivery/termination date for PERSON 2? / / ; and how many babies were delivered/expected? _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐Yes ☐No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐Yes ☐No

12. Are you **naturalized** or **derived citizen**? *(This usually means you were born outside of the U.S.)* ☐Yes ☐No
If Yes, please provide your Alien number and Certificate number. Alien number _____ Certificate number _____

13. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐Yes. Fill in their Immigration document type and Alien/Certificate number below.
a. Immigration Document type _____ b. Alien/Certificate number _____
c. Has PERSON 2 lived in the U.S. since 1996? ☐Yes ☐No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐Yes ☐No

14. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐Yes ☐No

15. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐Yes ☐No

16. Was PERSON 2 in foster care at age 18 or older? ☐Yes ☐No

**Please answer the following questions if PERSON 2 is under the age of 19.**

17. Did PERSON 2 have health insurance and lose it within the past 2 months? ☐Yes ☐No
a. **If yes**, end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 2 a full-time student? ☐Yes ☐No

19. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐Mexican ☐Mexican American ☐Chicano/a ☐Puerto Rican ☐Cuban ☐Other _____

20. **Race (OPTIONAL—check all that apply.)**

| | | | | |
|---|---|---|---|---|
| ☐ White | ☐ American Indian or Alaska Native | ☐ Filipino | ☐ Vietnamese | ☐ Guamanian or Chamorro |
| ☐ Black or African American | ☐ Asian Indian | ☐ Japanese | ☐ Other Asian | ☐ Samoan |
| | ☐ Chinese | ☐ Korean | ☐ Native Hawaiian | ☐ Other Pacific Islander |
| | | | | ☐ Other _____ |

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**Now, tell us about any income from PERSON 2 on the back.**

# STEP 2: PERSON 2

## Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 21.

☐ **Not employed**
Skip to question 31.

☐ **Self-employed**
Skip to question 30.

### CURRENT JOB 1:

21. Employer name and address

22. Employer phone number
( ) –

23. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

24. Average hours worked each WEEK

### CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

25. Employer name and address

26. Employer phone number
( ) –

27. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

28. Average hours worked each WEEK

29. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ Start working more hours ☐ None of these

30. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

31. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ How often?

☐ Pensions $ How often?

☐ Social Security $ How often?

☐ Retirement accounts $ How often?

☐ Alimony received $ How often?

☐ Net farming/fishing $ How often?

☐ Net rental/royalty $ How often?

☐ Other income $ How often?

Type: _____

Date Divorce/Separation was finalized or last modified: ___/___/____

32. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

**NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).

☐ Alimony paid $ How often? Date Divorce/Separation was finalized or last modified: ___/___/____

☐ Student loan interest $ How often?

☐ Health Insurance premiums, 401K, and Other Pre-Tax deductions $ Type: How often?

☐ Other deduction $ Type: How often?

33. **YEARLY INCOME:** **Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

| PERSON 2's total income **this year** | PERSON 2's total income **next year** (if you think it will be different) |
|---|---|
| **$** | **$** |

## THANKS! This is all we need to know about PERSON 2.

**If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.**

**NEED HELP WITH YOUR APPLICATION?** Visit gateway.ga.gov or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

## STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Attachment B.

## STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

- ☐ Medical Assistance _____
- ☐ Medicare _____
- ☐ TRICARE (Don't check if you have direct care or Line of Duty)
- ☐ VA Health Care Programs _____
- ☐ Peace Corps _____

☐ Employer insurance (If you check this box, complete the next four rows below and Attachment A.)

Name of health insurance _____

Policy number _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance _____

Policy number _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

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. If yes,** you'll need to complete and include Attachment A.

☐ **NO. If no, continue to Step 5.**

**Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):**
Please let us know if due to disability you require any reasonable modifications or communication assistance. Reasonable modifications allow an individual with a disability an equal opportunity to participate in all public assistance programs for which an individual may be otherwise eligible to receive.

**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?**

_____

For more information and additional ways to request a reasonable modification or communication assistance please see the attached Notice of ADA/Section 504 on page 9.

**PRA Disclosure Statement**
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must report any changes within 10 calendar days of the date of which the change occurs. I can visit gateway.ga.gov or call **1-877-423-4746** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by calling the DFCS Civil Rights, ADA/Section 504 Coordinator at 1-877-423-4746.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated. *(An incarcerated individual may still be found eligible for Medicaid.)*
  (Name of person)

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.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, Department of Labor (DOL), TALX (work number), the Department of Homeland Security and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

**Renewal of coverage in future years**

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Agencies, DFCS and Georgia Access to use income data, including information from tax returns. The Health Insurance Agencies, DFCS and Georgia Access will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

**If anyone on this application is eligible for Medical Assistance**

- I am giving to the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medical Assistance agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

**Express Lane Eligibility:**

Express Lane Eligibility (ELE) is an automatic process to enroll or renew eligible children under the age of 19 who are receiving Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Refugee Cash Assistance (RCA), Child Care and Parent Services (CAPS), or Women, Infants and Children (WIC) into the Medical Assistance program.

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

**My right to appeal**

If I think the Health Insurance Agencies, DFCS and Georgia Access has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Agencies, DFCS or Georgia Access that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Division of Family & Children Services (DFCS) at **1-877-423-4746**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

**Sign this application.** The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Attachment C.

| Signature | Date (mm/dd/yyyy) |
|---|---|
| | |

**NEED HELP WITH YOUR APPLICATION?** Visit gateway.ga.gov or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

# STEP 6 Mail completed application.

Mail your signed application to the address below:

**Division of Family and Children Services**
**Customer Contact Center**
**P.O. Box 4190**
**Albany, GA 31706**

## 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.**

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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.

## Notice of ADA/Section 504 Rights

### Help for People with Disabilities

The Georgia Department of Human Services and the Georgia Department of Community Health ("the Departments") are required by federal law* to provide persons with disabilities an equal opportunity to participate in and qualify for the Departments' programs, services, or activities. This includes programs such as SNAP, TANF and Medical Assistance.

The Departments provide reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities communication assistance, such as sign language interpreters. Our help is free. The Departments are not required to make any modification that would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens.

### How to Request a Reasonable Modification or Communication Assistance

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at (877) 423-4746 or the DCH Katie Beckett (KB) Team at 678-248-7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dfcs.georgia.gov/adasection-504-and-civil-rights, or you may obtain the DCH ADA Reasonable Modification Request Form at the KB office, online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, or you may email your modification request to DCH.ADAassistance@dch.ga.gov.

### How to File a Complaint

You have the right to make a complaint if the Departments have discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 47 Trinity Avenue SW, Atlanta, GA 30334, (877) 423-4746. For DCH, contact the KB Team ADA/Section 504 Coordinator at 2211 Beaver Ruin Road, Suite 150, Norcross, GA 30071 or P.O. Box 172, Norcross, GA 30091, (678) 248-7449. The DCH email is: dch.adarequests@dch.ga.gov.

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

**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.*

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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.