

This package includes the course material that you will need for the Food Stamps Non-Financial Eligibility Course.

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Note: You will use the verification charts and the Margaret Simmons application as you complete your self-study modules. The other three applications will be reviewed in your WebEx sessions.

Verification of Identity

Identity must be verified at initial application; it is the one point of eligibility that must be verified even for expedited applications. We do not require a picture ID. ALL possibilities for identity verification must be exhausted before an application is denied for this reason.

Any document which reasonably establishes identity must be accepted.

To verify identity:

FIRST, check DIS (Document Imaging System) to see if the client previously provided identity verification. DIS stores records submitted for OFI programs, Child Care, and Child Support records.

NEXT, if verification is not available, accept any reasonable verification from the client. This list is not all inclusive but provides examples of methods of verification of identity:

- ✓ Driver's license
- ✓ State ID
- ✓ Social Security Card
- ✓ Corrections ID
- ✓ Work ID
- ✓ Alien Card
- ✓ Birth Certificate
- ✓ Passport
- ✓ Military ID
- ✓ Health benefit ID - insurance, Medicaid, or Medicare
- ✓ Lease
- ✓ Mortgage statement
- ✓ Georgia DDS Interface, if results verify the client customer has a current and valid GA DL or GA ID – this is the only interface we use for identity
- ✓ ID from another assistance program such as WIC or child support
- ✓ Voter registration card
- ✓ Wage Stubs
- ✓ School records/ID
- ✓ Collateral Contact (policy manual Section 3035 includes detailed instructions)
- ✓ Statement from a responsible reference
- ✓ Utility bill (bill for gas, electricity, water, garbage, phone, etc.,)



When using a lease as identity verification, the worker must document how the lease was used to establish identity.

FINALLY, we **MUST** offer to provide a collateral contact for identity for ALL expedited applications and also for un-expedited applications if the client says that they will have difficulty getting ID.



The authorized representative for an AU cannot be the same person as the collateral contact whom we called to verify identity.

Verification of Residency

Residency must be verified at initial application; residency verification may be delayed for expedited applications.

Any document which reasonably establishes residency must be accepted.

To verify residency:

FIRST, check DIS (Document Imaging System) to see if the client provided proof of residency or if it has previously been verified. For example, if residency was previously verified with a GA Driver's License this may be used as verification of residency for the new application as well.

DIS checks OFI, Child Care, and Child Support records.

FINALLY, if verification is not available, accept any reasonable verification from the client. This list is not all inclusive but provides examples of methods of verification of residency:

- ✓ mortgage statement or lease
- ✓ rent or utility company receipts
- ✓ school records
- ✓ any other document proving residency
- ✓ Georgia DDS Interface, if results verify the client customer has a current and valid GA DL or GA ID – this is the only interface we use for residency
- ✓ GA State ID
- ✓ GA Voter registration card
- ✓ Wage Stubs if a home address is included
- ✓ written statement of responsible reference
- ✓ GA Driver's license

Verification of Citizenship

Citizenship must be verified at initial application or if a new member is added to the FS AU. Citizenship verification may be delayed for expedited applications.

Any document which reasonably establishes citizenship must be accepted.

To verify citizenship:

Citizenship is normally verified by Interface in Georgia Gateway. The verification source can be: electronically verified by SOLQ, SAVES, or Vital Records.

FIRST, check the system to see if citizenship has previously been verified. If the applicant receives Medical Assistance or TANF, citizenship is established through those programs.

Also check DIS (Document Imaging System) for citizenship verification. DIS checks OFI, Child Care, and Child Support records.

NEXT, check all available data matches for possible citizenship verification including (but not limited to):

- ✓ Georgia Vital Records information that matches the client's name and DOB
- ✓ SDX/BENDEX Interface records that indicate receipt of RSDI disability (not RSDI on another person's account), Medicare, or SSI
- ✓ Gateway records that indicate the member received Newborn Medicaid at any time

FINALLY, if verification cannot be obtained through a data match, accept any reasonable verification from the client including:

- ✓ Birth certificate
- ✓ Certificate of Citizenship (N- 560, N-561, N-600, or N-643)
- ✓ Naturalization certificate (N-550) (N-570)
- ✓ Report of Birth Abroad of U.S. Citizen (Form FS-240, FS 545, DS 1350)

- ✓ U.S. Citizen I.D. card (I-197 or I-179)
- ✓ U.S. Passport
- ✓ Consular Report of Birth
- ✓ American Indian card (I-872), first issued by INS, now known as the United States Citizenship and Immigration Services (USCIS) in 1983
- ✓ Northern Mariana Primary I.D. card (I-873), issued prior to 1986 and to applicants born prior to 11/3/86 by INS
- ✓ Court records of parentage, juvenile proceedings, or child support indicating place of birth
- ✓ Property records verifying U.S. citizenship status
- ✓ Religious record of birth recorded in the U.S or its territories within three months of birth. The document must show either the date of birth or the individual's age at the time the record was made
- ✓ Any document that establishes place of birth or U.S citizenship such as records from SSA, VA, local government agencies, hospitals, and a clinic's record of birth or parentage.
- ✓ Verification of citizenship established through another public assistance program or governmental agency. For example, the Medicaid or TANF program.
- ✓ Evidence of civil service employment by the U.S. government before 6/1/1976
- ✓ Early school records showing the date of admission to the school, the child's date and place of birth, and the name(s) and place(s) of birth of the parent(s)
- ✓ Census record showing the name, U.S. citizenship or a U.S. place of birth, and the date of birth or age of the individual
- ✓ Adoption Finalization Papers showing the child's name and place of birth in one of the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands (St. Thomas, St. John, St. Croix), Northern Mariana Islands (Saipan, Rota, Tinian), American Samoa, or Swains Island
- ✓ A Third Party Collateral Statement of a person who has knowledge of an individual's place of birth (used only when no other method of verification is available)

Determining AU Composition

| | |
|---------------|--|
| Step 1 | <ul style="list-style-type: none">○ Make sure everyone living in the home is listed on the application.○ Determine who customarily purchases food and prepares meals together or intend to purchase and prepare their meals together. Individuals who declare that they purchase food and prepare meals together, or intend to purchase and prepare their meals together, must be one AU.○ Determine relationship among individuals in the home. |
| Step 2 | Consider potential separate AU status if the individual states they purchase and prepare their meals separately or they intend to purchase and prepare their meals separately. |
| Step 3 | <p>The following people must be in one AU, even if they say they Purchase Food and Prepare Meals separately:</p> <ol style="list-style-type: none">1. SPOUSES (living together) must be ONE AU2. PARENTS living with their biological, adopted and step- CHILD(REN) UNDER AGE 22 must be ONE AU3. MINOR CHILD(REN) (under age 18) under PARENTAL CONTROL of an AU member, other than their parent, who is exercising parental control of minor child(ren) must be ONE AU |

| | |
|-------------------|---|
| STEP 4 | <p>Exclude the following individuals from the AU, even if they customarily purchase food and prepare meals together:</p> <ul style="list-style-type: none"> • Ineligible Students • Ineligible <u>ABAWDs</u> • Enumeration sanctioned individuals • Ineligible Aliens • Intentional Program Violation (IPV) disqualified individuals • Work Sanctioned individuals • Fleeing Felons and Probation/Parole Violators • Individuals convicted of an offense classified as a felony related to possession, use, or distribution of a controlled substance after 8/22/96) <u>who are in violation of their parole or probation</u> • Individuals 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 2/7/14 <u>and in violation of their parole or probation</u> |
| STEP 5 | <p>Refer to chart 3205.1 in the policy manual for Special Exceptions for AU Composition.</p> |

Student Eligibility Criteria

A student enrolled in an institution of higher education, at least half time, is eligible to participate in the Food Stamp Program if she/he qualifies for one of the following exemptions:

- 17 or younger or age 50 or older
- Physically or mentally unfit
- Employed and paid for an average of 20 hours per week (in-kind income does not qualify for this exemption)
- Self-employed for an average of 20 hours per week and earns the equivalent of 20 hours times the federal minimum wage (in-kind income does not qualify for this exemption)
- Participates in an on-the-job training program
- Eligible to participate in a state or federally funded work study program
- Has an Expected Family Contribution (EFC) of \$0 as calculated from the information the student provided on their Free Application for Federal Student Aid (FAFSA) – each student receives a Student Aid Report (SAR) once the FAFSA is completed that lists the EFC amount
- Receives TANF benefits
- Participates in TANF work requirements with education component

- Assigned or placed in an institution of higher education through WIA, JTPA or the Trade Act of 1974

The Job Training Partnership Act (JTPA) was replaced by the Workforce Investment Act (WIA), which was then replaced by the Workforce Investment and Opportunity Act (WIOA). The WIOA is the current federal work program through the Department of Labor that is designed to help job seekers and workers access employment, education, training, and support services to succeed in the labor market and match employers with skilled workers they need to compete in the global economy.

- Participates in SNAP Works, which is the Food Stamp Employment and Training (E&T) program with education component or another approved E&T program or activity
- Responsible for the care of a dependent child under 6
- Responsible for the care of a dependent AU member between 6-12, without adequate childcare that would allow the student to attend class and work 20 hours per week or participate in work study
- Single parent (or parental control), enrolled full-time, and responsible for the care of a dependent child under 12 in the same AU as the parent



Application for Benefits

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

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

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

DFCS offers the following services:

Food Assistance

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



Cash Assistance/Employment Support Services

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



- **Grandparents Raising Grandchildren (GRG)** will provide the support necessary so that children can be cared for in the homes of their grandparents.



Medical Assistance

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



Community Outreach Services

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

How Do I Apply for Benefits?

Step 1. Fill out the application.

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

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

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



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

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

Frequently Asked Questions

How long does it take to get benefits?

| | |
|---------------------|---------------|
| Food Stamps (SNAP): | up to 30 days |
| TANF: | up to 45 days |
| Medicaid: | 10 to 60 days |

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

How much will I get?

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

How will I get my benefits?

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

You may be asked to provide the following information:

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

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



Application for Benefits

If you are applying for Food Stamps (SNAP), TANF and/or Medicaid, you can file an application for benefits with only your name, address, and signature. However, it may help us to process your application quicker if you complete the entire form. You may use this form to file a joint application for more than one program or for the Food Stamp (SNAP) program only. Your (SNAP) application will not be denied solely on the basis that your application for another program has been denied. We will make a separate eligibility determination for your Food Stamp (SNAP) application. If you are in an institution and applying for Food Stamps (SNAP) and SSI at the same time, the filing date of your application is the date you are released from the institution.

Step 3. Talk with us.

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

How do we use the applicant's personal information?

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

Can someone else apply for me?

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

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



Application for Benefits

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

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

Food Stamps (Supplemental Nutrition Assistance Program (SNAP))

The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, is a federally funded program that provides monthly benefits to low-income households to help pay for the cost of food. The program also provides nutrition education to families to meet their food and nutritional needs and provides employment and training opportunities to help families gain employment that leads to less dependence on SNAP.

Temporary Assistance for Needy Families (TANF)

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

Grandparents Raising Grandchildren (GRG)

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

Refugee Cash Assistance

The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, and unaccompanied refugee minors.

Medicaid

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

Please fill out the chart below about the applicant.

| | | | |
|--|----------------------|---|--------|
| First Name Margaret | Middle Initial | Last Name Simmons | Suffix |
| Street Address Where You Live 2640 Lincoln Blvd | | Apt | |
| City Atlanta | State GA | Zip Code 30303 | |
| Mailing Address (If different) PO Box 5680 | | | |
| Main Telephone Number 404-656-1200 | Other Contact Number | Email Address (optional) | |
| Electronic Communication: Yes <input type="checkbox"/> or No <input type="checkbox"/> (optional) | | | |
| What is your Preferred Language? English | | If an interview is required, will you need an interpreter? Yes <input type="checkbox"/> or No <input checked="" type="checkbox"/> | |

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?



Application for Benefits

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

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. 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)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of \$3750 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.

Margaret Simmons

Signature

07/05/2016

Date

Witness Signature if signed by "X"

Date

Authorized Representative:

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

Authorized Representative 1 Program Types: Food Stamps (SNAP) TANF Medical Assistance

Authorized Representative 1 Duties: Sign application on applicant's behalf

Complete and submit renewal form Receive copies of notices and other communication

Act on behalf of applicant in all other matters Receive a TANF benefit card (EPPIC)

Person Name 1: _____

Organization Name 1 (if applicable): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Yes _____ or No _____ (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): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Yes _____ or No _____ (optional) Email Address (optional) _____

Preferred Language: _____ Is an interpreter needed? Yes _____ or No _____



Application for Benefits

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 Office Use Only Date Received: _____



Application for Benefits

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

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

1. Are you or any household member a migrant or seasonal farm worker?

Yes

No

If yes, who _____

2. Total Gross earned income that will be received for this month:

\$ 800

Employer Name FedEx

Employment Begin Date 1-16-16 Employment End Date _____

Rate of Pay \$10 Hours Worked Weekly 20

How Often Are You Paid: weekly bi-weekly/semi-monthly/monthly (circle one)

3. Total Gross unearned income that will be received for this month:

\$ _____

Type of Unearned Income _____ Amount _____

How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

Type of Unearned Income _____ Amount _____

How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

4. Total earned and unearned income for this month:

\$ 800

5. How much money do you and all household members have in cash or in the bank? \$ 45

6. What is the monthly amount of your rent, mortgage, property taxes, and/or homeowner's insurance? \$ 300

7. What is the total amount of your electric, water, gas, and/or other utilities this month? \$ 75

(Exclude past due and late fee amounts in the total)

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

Electric Gas Window or central air conditioner Kerosene oil Wood

b. Have you received energy assistance in the last 12 months? Yes No If yes, amount received \$ _____



Application for Benefits

Tell Us about the Applicant and All Household Members

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

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

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.

| NAME First | Middle Initial | Last | Relationship | Is this person applying for benefits? (Y/N) | Does this person need health coverage? (Y/N) | Birth Date Format (--/-/-) | Social Security Number (Applicants Only) | Sex (M/F) | Hispanic or Latino? (Optional) | Race Code (Optional) | Are you a U.S. citizen, U.S. national, or qualified alien/immigrant? (Applicants only) (See codes Below) (Y/N) |
|------------------|----------------|------|--------------|--|---|----------------------------------|---|--------------|-----------------------------------|-------------------------|---|
| Margaret Simmons | | | SELF | Y | N | 12/05/84 | 582-01-XXX | F | N | BL | Y |
| Tina Simmons | | | daughter | Y | N | 5/15/04 | 582-02-XXX | F | N | BL | Y |
| Susan Simmons | | | daughter | Y | N | 11/25/10 | 582-03-XXX | F | N | BL | Y |
| Roger Simmons | | | son | Y | N | 3/14/03 | 582-04-XXX | M | N | BL | Y |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

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.



Application for Benefits

If you or other household applicants are not U.S. Citizens or U.S. Nationals, complete the following chart:

| NAME | | | Immigration document type | Document ID number | Have you lived in the U.S. since 1996? | Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? |
|-------|----------------|------|---------------------------|--------------------|--|--|
| First | Middle Initial | Last | | | (Y/N) | (Y/N) |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

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)

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? 11-13-16; and how many babies expected? 1

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: Margaret Simmons Unborn baby's father's name: _____

Father's address: _____



Application for Benefits

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

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

If yes:

a. Who: _____

b. Where: _____

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

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



Application for Benefits

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, please complete the section below:

Who: _____

When: _____

- Are you in compliance with the terms of probation related to any sentence received as a result of a felony conviction? (Food Stamps (SNAP) only) Yes No
- Are you in compliance with the terms of parole related to any sentence received as a result of a felony conviction? (Food Stamps (SNAP) only) Yes No
- Have you successfully completed **all the terms of probation or parole** related to any felony related conviction? (Food Stamps (SNAP)) 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: _____

Tell Us about the Applicant and All Household Members Income

Do you or anyone you are applying for receive any type of income such as: wages, tips, bonuses, self-employment, Social Security/Railroad Retirement, other disability, pensions, unemployment, or any other income? For Food Stamps (SNAP) and TANF, please also list income such as: VA income, child support, money from other people or workers compensation. If yes, complete the chart below.

| Household Member Name with Income | Type of Income | Employer Name /Source of Income | Monthly Amount (Before Deductions) | How Often received (monthly, biweekly, weekly) | Pay Per Hour | Hours per Week | DATE (S) PAID |
|-----------------------------------|----------------|---------------------------------|------------------------------------|--|--------------|----------------|---------------|
| Margaret | wages | FedEx | \$800 | weekly | \$10 | 20 | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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



Application for Benefits

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

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

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

| | | | |
|-----------------------------------|--|-----------------------------------|--|
| Checking Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Funeral Plans/Prepaid Burial Item | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Savings Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Burial Plots or Contracts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Government Bonds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stocks and Bonds | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Trust Funds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (IRA, CD, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Real Property/Homeplace Property? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

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

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

| Household Member Name with Resource | Type of Resource | Account/Policy Number | Value | Name of Bank, Insurance Company, etc. |
|-------------------------------------|------------------|-----------------------|-------|---------------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you or your spouse own a vehicle? If so, please describe below. Yes No

| Household Member Who Owns Vehicle | Vehicle Make | Model | Year | Amount Owed |
|-----------------------------------|--------------|-------|------|-------------|
| | | | | |
| | | | | |
| | | | | |

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

If yes, please complete the following information.

| Policy Owner | Insurance Company | Policy Number | Face Value | Cash Value |
|--------------|-------------------|---------------|------------|------------|
| | | | | |
| | | | | |

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

Do you pay for the care of a dependent child or a disabled adult household member? Yes No If yes, complete the chart below.

| Person who requires care | Person who pays for care | Reason for care | Provider's Name/Number | Amount paid to Provider | How often paid |
|--------------------------|--------------------------|-----------------|------------------------|-------------------------|----------------|
| | | | | | |
| | | | | | |



Application for Benefits

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: _____

Does anyone in the household pay child support to someone living outside of the home? Yes No

If yes, complete the chart below.

| Household Member Obligated to Pay | Name of Child for Whom Support is paid | Obligated Amount to Pay | Actual Amount Paid | To Whom is Child Support Paid? |
|-----------------------------------|--|-------------------------|--------------------|--------------------------------|
| | | | | |
| | | | | |

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

Does anyone 60 years of age or older or disabled have medical expenses? Yes No If yes, complete the chart below.

| Household Member Who Has Expense | Type of Expense (doctor visits, hospital visit, prescriptions, Medicare or health Insurance premiums, glasses) | Amount Owed | Still Owed? Yes/No | Date Paid | Will Insurance Pay? Yes/No |
|----------------------------------|--|-------------|--------------------|-----------|----------------------------|
| | | | | | |
| | | | | | |
| | | | | | |

Does anyone 60 years of age or older or disabled have medical expenses for transportation? Yes No

If yes, complete chart below.

| Purpose of the trip (doctor or hospital visit; pharmacy pick-up) | Total miles driven: | Cost of taxi, bus, parking or lodging: |
|--|---------------------|--|
| | | |
| | | |

Do you or any household member have shelter and utility expenses? Yes No If yes, complete the chart below.

| Expense | Amount | How Often? | Who paid? |
|--------------------|--------|------------|-----------|
| Rent/Mortgage | \$300 | monthly | Margaret |
| Property Taxes | | | |
| Property Insurance | | | |
| Electricity | \$50 | monthly | Margaret |
| Gas | | | |
| Garbage | | | |
| Telephone | \$25 | monthly | Margaret |
| Other | | | |



Application for Benefits

Do you share monthly household expenses with anyone in the home? Yes No

If yes, who? _____

Comments/Documentation _____

Paid to whom _____ Amount paid \$ _____ per _____

Landlord's Name _____

Landlord's address: _____

Does someone else pay any of these household bills for you? Yes No If yes, complete the chart below:

| | |
|----------------------|---|
| Who pays the bill? | What bills are paid? |
| What amount is paid? | To whom does this person pay the bills? |

Please complete the following information if applying for Medicaid.

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? Yes No

If yes, who? (list each person who plans to file) _____

2. Will any of the tax filers listed file jointly with a spouse? Yes No If yes, please list spouse's name: _____

3. Will any of the tax filers claim any dependents on their tax return? Yes No If yes, please list name(s) of dependents _____

4. Will anyone be claimed as a dependent on someone else's tax return? Yes No If yes, please list the name of the tax filer and the dependent: (Filer) _____

(Dependent) _____

How is the tax dependent related to the tax filer? _____

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

Alimony paid \$ _____ How often? _____ Student loan interest \$ _____ How often? _____

Other deductions \$ _____ How often? _____ Type: _____

Other health coverage

1. Does anyone have other health insurance that covers anyone in your household? Yes No

If you answered yes to question 4 above, please complete the following information and Attachment A:

| Name of Policy holder | Health Insurance Company Name, Address and Telephone Number | Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical) | Name of Persons Covered | Effective Date | Policy Number |
|-----------------------|---|--|-------------------------|----------------|---------------|
| | | | | | |
| | | | | | |

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

Yes No If yes, you need to complete Attachment A.

Is this a state employee benefit plan? Yes No



Application for Benefits

3. Have you or anyone listed on this application lost any health coverage in the last 2 months?
 - a. Yes If yes, why was it lost? _____
 - b. No
4. Was anyone in Foster Care at age 18 applying for Medicaid? Yes No
5. Is anyone in your household American or Alaska Native? Yes No
If yes, complete Attachment B.

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

1. Is anyone applying for health coverage blind or disabled?
 Yes No If yes, please list name _____
2. Are you or your spouse currently covered by Medicare?
 Yes No If yes, please list name _____
3. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?
 Yes No If yes, date of SSI application: _____
4. Are you applying for someone who is now deceased and has unpaid medical bills within the last three (3) months?
 Yes No
5. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
 Yes No
6. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?
 Yes No
7. Are you applying for Medicaid to help pay for community-based waiver services such as Community Care Services, NOW/COMP, Hospice Care, Independent Care Waiver, or the Deeming Waiver (Katie Beckett)?
 Yes No



Application for Benefits

Food Stamp (SNAP) Program Penalties

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

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

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

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

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

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

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

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

TANF Program Penalties

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

- Any household member who hides information and does not report changes on time or does not tell the truth will lose TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation. The misuse of the cash assistance funds or TANF DEBIT card to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities "strip clubs", poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, race tracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons is strictly prohibited and will result in a loss of TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member hiding information or you do not report changes on time or do not tell the truth and are convicted, you may not get TANF for 6 months for the first violation, 12 months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member guilty of giving false information about where you live so you can receive benefits in more than one state, you will be barred for 10 years.
- If a court convicted you of a drug-related charge, controlled substance, or a serious violent felony on or after 1/1/1997, you or that household member will not be eligible and/or permanently disqualified.



Application for Benefits

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

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. 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)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of \$3750 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.

Margaret Simmons

07/05/2016

Applicant's Signature

Date _____

Authorized Representative's Signature

Date

VOTER REGISTRATION INFORMATION

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

Yes

X No

I do not want to answer the Voter Registration question

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

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

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at 2 Martin Luther King Jr. Drive, 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.



Application for Benefits

(Keep these documents for your information)

What Do the Words Used in this Application Mean?

This chart explains the words we have used in this application.

| | |
|--|--|
| Applicant | An individual who chooses to apply for or to receive public assistance or benefits. |
| Assistance Unit (AU) | An assistance unit includes <i>eligible</i> individuals who live together and receive public assistance/benefits. |
| Caretaker | A parent, relative or legal guardian who applies for and receives TANF with children in his or her care. |
| Disqualified | The action taken to remove an individual from a Food Stamp (SNAP) or TANF case because they did not tell the truth and received benefits that they should not have received. |
| Electronic Benefit Transfer (EBT) | The system used in Georgia to pay benefits to individuals who are eligible for Food Stamps (SNAP). Individuals receiving assistance are issued an EBT debit card, which is used to access their Food Stamp (SNAP) accounts. |
| Electronic Communications | 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. |
| EPPICard debit MasterCard | 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. |
| Grantee Relative | A parent, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children. |
| Gross Income | A person's total income before taking taxes or other deductions into account. |
| Household Members | Individuals who live in your home. For Food Stamps (SNAP), individuals who live together and purchase and prepare their meals together. |
| Income | Payments such as wages, salaries, commissions, bonuses, worker's compensation, disability, pension, retirement benefits, interest, child support or any other form of money received. |
| Middle Class Tax Relief Act of 2012 | 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/averns, bingo halls, racetracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons. The use of cash assistance funds or the TANF Debit Card at these businesses will constitute an intentional program violation (fraud) on the part of the recipient. |
| Migrant Farm Workers | Individuals who are seasonal farm workers and who move from one home base to another to work or look for farm work. |
| Non-applicant | An Individual who does NOT apply for or receive public assistance/benefits; non-applicants are not required to provide an SSN, citizenship, or immigration status. |



Application for Benefits

| | |
|---|---|
| Qualified Alien/Immigrant | <p>A <i>qualified alien/immigrant</i> is a person who is legally residing in the U.S. who falls within one of the following categories:</p> <ul style="list-style-type: none"> • a person <i>lawfully admitted for permanent residence</i> (LPR) under the Immigration and Nationality Act (INA); • <i>Amerasian</i> immigrant under section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988; • A person who is <i>granted asylum</i> under section 208 of the INA; • <i>Refugees</i>, admitted under section 207 of the INA; • A person <i>paroled</i> into the US under section 212(d)(5) of the INA for at least one year; • A person whose <i>deportation</i> 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 <i>granted conditional entry</i> under section 203(a)(7) of the INA as in effect prior to April 1, 1980; • <i>Cuban or Haitian</i> immigrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980; • <i>Victims of human trafficking</i> under section 107(b)(1) of the Trafficking Victims Protection Act of 2000; • <i>Battered immigrants</i> who meet the conditions set forth in section 431 (c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended; • <i>Afghan or Iraqi</i> immigrants granted special immigrant status under section 101(a)(27) of the INA (subject to specified conditions); • <i>American Indians</i> 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; • <i>Hmong or Highland Laotian tribal members</i> that rendered assistance to U.S. personnel by taking part in military or rescue operation during Vietnam Era (8/05/1964 – 5/07/1975). <p>For Medical Assistance Applications 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.</p> |
| Resources | Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance. |
| Seasonal Farm Workers | Individuals who work at certain times of the year planting, picking, or packing produce. They are hired on a temporary basis when a job requires more workers than the farm employs on a regular basis. |
| Trafficking in the Food Stamp/SNAP Program | <p><i>Trafficking</i> SNAP benefits means: (1) Buying, selling, stealing, or otherwise exchanging SNAP benefits issued and accessed via EBT cards, card numbers and PIN numbers or by manual voucher and signature, for CASH or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; (2) The exchange of firearms, ammunition, explosives, or controlled substances; (3) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount; (4) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; (5) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food; (6) Attempting to buy, sell, steal, or otherwise affect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone.</p> |

For All Medicaid Applicants:

To report suspected Medicaid fraud on recipients or providers, call the Georgia Department of Community Health-Office of Inspector General at (local) (404) 463-7590 or (toll free) (800) 533-0686; by email at oiganonymous@dch.ga.gov; by mail at Department of Community Health, OIG PI Section, 2 Peachtree Street NW, 5th Floor, Atlanta, GA 30303; 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 (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://dfcs.georgia.gov/adasection-504-and-civil-rights>, or you may obtain the DCH ADA Reasonable Modification Request Form at the DCH Katie Becket (KB) 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 NW, Ste. 19-454, Atlanta, GA 30303, (404) 657-3735. For DCH, contact the KB TEAM ADA/Section 504 Coordinator at 2211 Beaver Ruin Road, Ste. 150, Norcross, GA 30071, or PO Box 172, Norcross, GA 30091, (678) 248-7449.

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.

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 Services (DHS)** policy, 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 NW, 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 Impairment Program at 2 Peachtree Street NW, Ste. 29-103, Atlanta, GA 30303, or call (404) 657-5244.

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.

Nondiscrimination Statement

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

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027), found online at <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-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.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the [State Information/Hotline Numbers](#) (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

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

This institution is an equal opportunity provider.



Division of Family and
Children Services



Rights and Responsibilities

Welcome to the Georgia Division of Family and Children Services!

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).

Community Outreach Services

For more information about other DHS services, please visit our website at <http://dfcs.georgia.gov> or call 1-877-423-4746.

We are giving you this information to help you understand your rights and responsibilities when you receive help for Food Assistance, Cash Assistance and Medical Assistance. Please read over the Rights and Responsibilities for the programs in which you are applying and sign the signature page. If you are applying for someone else, these rights and responsibilities apply to that person as well.

What Are My Rights in the Food Stamp, TANF and Medicaid Programs?

In 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.
- **request a fair hearing in writing or in person.** You have the right to be represented by a household member, legal counsel, a relative, a friend or other spokesperson. If you are not satisfied with the action we have taken on your case, you can request a hearing by contacting the county office where you applied for benefits or by calling 1(877) 423-4746.
- **review some of the material and information in your case file.** However, you may not be able to see all of the information in the case file, such as names of people who have given us information about you or your household members or information about any criminal prosecutions involving you or any of your household members.
- **decide if you want to provide Social Security Number (SSN), citizenship, or immigration status information.** To qualify for public assistance, individuals must be a U.S. citizen, U.S. National, or eligible immigrant. Pursuant to 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, DFCS is authorized to request your and your household members SSN.

Individuals who are applying for public assistance must provide or apply for an SSN, and/or verify their citizenship or immigration status. Some immigrants are eligible and some are not, depending on their legal status. If you or anyone in your household does not have an SSN, we can help you apply for one. Applying for an SSN will not delay a decision on your application for benefits. If you are applying for emergency medical services only, you do not have to provide your SSN or information about your immigration status. Emergency Medicaid, including labor and delivery, is available for pregnant non-qualified and undocumented immigrants.

An individual, who is not applying for public assistance and who does not provide an SSN, citizenship or immigrant status may be designated as a non-applicant. A non-applicant is not required to provide an SSN, citizenship, or immigrant status but is required to provide other information that may affect the eligibility of other applicant household members such as income or resources.



Rights and Responsibilities

A non-applicant is not eligible to receive benefits. Only the people who give information to us about their SSN, citizenship, or immigration status will be eligible to receive benefits. We will use this information to check the Income and Eligibility Verification System (IEVS). We will also match your information with other Federal, state, and local agencies to verify your income and eligibility, wage information and work activities. This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a Food Stamp claim, the information on this application, including SSNs, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim.

We will not share your information with the United States Citizenship and Immigration Services (USCIS); however, if immigration status information has been submitted on your application, this information may be subject to verification through USCIS and may affect your household's eligibility and benefit level.

We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status. Applying for or receiving **Food Stamp benefits does not make a non-citizen a public charge.**

Receiving or accepting **Supplemental Security Income (SSI), TANF cash assistance, Institutionalized Long-Term Care Medicaid, state General Assistance or Supplemental Nutrition Assistance Program (SNAP)** could make a non-citizen a public charge if all eligibility criteria are met. However, receiving these benefits does not automatically make an individual inadmissible or ineligible to adjust his/her status to lawful permanent resident on a public charge basis. A "public charge" means you are a person who is likely to become "primarily dependent" on the government to maintain your way of life, as demonstrated by either the receipt of public cash assistance for income maintenance or by institutionalization for long-term care at the government's expense."

If you are considered to be a public charge, you will not be deported, or denied permanent status because you have applied for or receive public assistance.

- **decide if you want to provide information about your race and ethnicity.** We collect data on race and ethnicity 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.

What Are My Responsibilities in the Food Stamp, TANF and Medicaid Programs?

In all programs, 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 lose your benefits or be subject to criminal prosecution for knowingly providing false information.
- providing proof that you or anyone in your household applying for benefits is a U.S. citizen or qualified immigrant. **Note:** Your worker will give you a list of ways you can prove your citizenship or immigration status.
- reporting certain changes in your household situation. Each program has different reporting requirements. See the responsibilities section for each program for things you need to report.



Rights and Responsibilities

What Other Responsibilities Do I Have in the Food Stamp Program?

In the Food Stamp Program, you are also responsible for:

- 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.
- repaying benefits, you should not have received.
- reporting when your household's total gross monthly income is more than 130% of the Federal Poverty Level for the household size. If you are a working adult with no children, you must report when your work hours fall below 20 hours per week or 80 hours per month. You must report these changes within 10 days from the end of the month in which the increase or change occurred. You may be given a Notice of Simplified Reporting Requirements, which explains more about this requirement.
- reporting when your household receives substantial lottery and gambling winnings. This is a cash prize won in a single game. If you or a household member receives lottery or gambling winnings, gross amount of \$3500 or more (before taxes or other amounts are withheld), you must report these winnings within 10 days from the end of the month in which the household member received the winnings.

Food stamp households **CAN NOT** use their benefits to purchase non-food items such as beer, wine, liquor, cigarettes, tobacco, pet foods, soaps, paper products and household supplies.

Food stamp households also **ARE NOT** allowed to purchase food on credit with their benefits.

Food stamp households **CAN NOT** give false information or hide information to get benefits that their household should not get.

Food stamp households **CAN NOT** use Food Stamps or EBT cards that are not theirs and should not let someone else use their card.

Food Stamp households **CAN NOT** trade or sell Food Stamps or EBT cards for illegal items such as firearms, ammunition, or a controlled substance (illegal drugs).

What Are My Rights and Responsibilities for Reporting Household Expenses in the Food Stamp Program?

In the Food Stamp Program, certain household expenses such as shelter costs, medical bills, dependent care costs, and child support paid outside the home may affect the amount of benefits you receive.

If you have heating or cooling expenses, you may be eligible to receive the standard utility allowance.

If you have only one utility expense and it is NOT a heating or cooling expense, you may be eligible to receive a deduction for the actual expense incurred.

If you have only one telephone expense and no heating or cooling expenses, you may be eligible to receive the standard telephone allowance. If you want us to consider these expenses, you are responsible for reporting and verifying them. If you fail to report or verify actual utility expenses, we will not use them to determine your benefit amount.



Division of Family and
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PeachCare
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What Are the Penalties in the Food Stamp Program?

The Food Stamp Program penalties are provided in the chart below.

| Intentional Program Violations | |
|--|--|
| If you or any household member... | You will be INELIGIBLE |
| <ul style="list-style-type: none">▪ hides information or does not tell the truth;▪ uses EBT cards that belong to someone else;▪ uses FS benefits to buy alcohol or tobacco, trades or sells FS benefits or | <ul style="list-style-type: none">▪ for 12 months for the first offense,▪ 24 months for the second offense,▪ and permanently for the third offense. |
| <ul style="list-style-type: none">▪ has used or received FS benefits in a transaction involving the sale of a controlled substance | <ul style="list-style-type: none">▪ for 24 months for the first offense and▪ permanently for the second offense. |
| <ul style="list-style-type: none">▪ has used or received FS benefits in a transaction involving the sale of firearms, ammunition, or explosives after 8/22/96 | <ul style="list-style-type: none">▪ permanently for the first offense. |
| <ul style="list-style-type: none">▪ has been convicted for trafficking benefits for an amount of \$500 or more after 8/22/96 | <ul style="list-style-type: none">▪ permanently for the first offense. |
| <ul style="list-style-type: none">▪ has a felony conviction because of behavior related to the possession, use or distribution of a controlled substance (drugs) after 8/22/96 | <ul style="list-style-type: none">▪ until you are in compliance with the terms of probation or parole.▪ until you complete <u>all</u> the terms of probation or parole. |
| <ul style="list-style-type: none">▪ is fleeing to avoid prosecution, custody, or Confinement for a felony | <ul style="list-style-type: none">▪ until you are no longer fleeing. |
| <ul style="list-style-type: none">▪ Is violating a condition of your probation or parole | <ul style="list-style-type: none">▪ until you are no longer a probation or parole violator. |
| <ul style="list-style-type: none">▪ has given false information about where you live or about your identity (who you are) to get multiple FS benefits in more than one area after 8/22/96 | <ul style="list-style-type: none">▪ for 10 years. |



Rights and Responsibilities

What Other Rights Do I Have in the TANF Program?

In the TANF Program, you have a right to:

- be excused from certain rules if you are a victim of domestic violence. Your case manager will talk to you about the rules that you will not have to follow.

What Other Responsibilities Do I Have in the TANF Program?

In the TANF Program, you are responsible for:

- 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, your case may be denied or closed.
- repaying benefits, you should not have received.
- participating in a work activity if you are a parent or an adult included in the TANF benefit, unless you are exempt. We will work with you to find the best work activities to help you become self-sufficient. We may have to reduce or stop your TANF benefits if you do not cooperate with us, and there is not a good reason.
- reporting that you or someone included in your TANF benefit has received or is expecting to receive a lump sum of money. Your TANF benefits may stop for one or more months and your family may have to live on the lump sum for several months.
- cooperating with the Division of Child Support Services if you receive TANF benefits. You must help the Division of Child Support Services determine who is the father(s) of your child/children and help them get a court order for child support. If you do not cooperate with them and there is not a good reason, your TANF benefits may stop.
- notifying your case manager if you want to receive child support money instead of your TANF benefits. When you get TANF benefits, you may not receive all of your child support payment. You may receive only a portion of it called a "gap" payment. The state keeps the rest of the child support payment to pay back the TANF benefits that you receive.
- reporting certain changes in your household situation about you and other eligible household members within 10 days of knowing about them. Please let us know if you or any member of your household:
 - starts or stops receiving any unearned income
 - changes jobs, gets a new job, quits a job or gets laid off
 - moves in or out of your home
 - has a baby or there is any other change, for example,
 - a child drops out of school
 - a child is absent from the home for a period of 45 consecutive days or longer
 - the whole family moves to another county or state, or,
 - someone dies



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Rights and Responsibilities

What Are the Penalties in the TANF Program?

In the TANF Program, there are penalties:

| If you ... | You will lose TANF benefits ... |
|--|--|
| <ul style="list-style-type: none">• hide information, do not report changes on time or do not tell the truth | <ul style="list-style-type: none">• for 6 months for the first violation; for 12 months for the second violation; permanently for the third violation. |
| <ul style="list-style-type: none">• hide information, do not report changes on time or do not tell the truth and are convicted in a court of law | <ul style="list-style-type: none">• for 6 months for the first violation; for 12 months for the second violation; permanently for the third violation. |
| <ul style="list-style-type: none">• give false information about where you live so you can receive benefits in more than one state and are convicted on or after 01/01/1997 | <ul style="list-style-type: none">• for 10 years. |
| <ul style="list-style-type: none">• Individuals convicted of other IPVs committed on or after 07/01/1998 | <ul style="list-style-type: none">• for 6 months for the first violation; for 12 months for the second violation; permanently for the third violation. |
| <ul style="list-style-type: none">• are convicted of a drug-related charge or a serious violent felony, on or after 1/1/97 | <ul style="list-style-type: none">• permanently. |
| <ul style="list-style-type: none">• Individuals convicted of an IPV for using cash assistance funds or the TANF EBT transactions performed at prohibited places on or after 06/01/2012 | <ul style="list-style-type: none">• for 6 months for the first violation; for 12 months for the second violation; permanently for the third violation. |



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Rights and Responsibilities

What Other Rights Do I Have in the Medicaid Program?

In the Medicaid Program, you have a right to:

- receive Medicaid even if you have other health insurance.
- choose your Medicaid doctor or provider. Always ask your doctors if they accept Medicaid as payment for their services.
- have your Medicaid application approved or denied within 10, 45 or 60 days from the date you apply, depending on the type of Medicaid.
- be excused from providing information about your children's absent parent or from pursuing medical support from the absent parent if you have a good reason such as domestic violence. Talk to your case manager if you think you have a good reason.

What Other Responsibilities Do I Have in the Medicaid Program?

In the Medicaid Program, you are also responsible for:

- telling your worker if you or your children have other health insurance. If the health insurance changes or ends, you must tell your worker within 10 days. The health insurance information is sent to the Department of Community Health. In most cases, your other health insurance must pay your medical expenses first. You must tell your doctor or other health care providers that you have other insurance so that they can bill the other health insurance providers before they bill Medicaid.
- cooperating with the Medicaid Estate Recovery Program if you are:
 - a resident in a nursing home
 - a resident in an intermediate care facility for mental retardation
 - a resident in another mental institution where medical care is paid by Medicaid
- cooperating with the Medicaid Estate Recovery Program if you are age 55 years or older and:
 - receive home and community-based services.
 - are enrolled in and receive services through a waiver program.
- 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).
- reporting changes about you and the other people in your Medicaid case. Please report:
 - if you or other household members move
 - if you or other household members change jobs, get a new job, quit a job or get laid off.
 - if you or other household members have a change in income or resources
 - if a family member moves in or out of your home
 - if you or another household member inherits or receives money or property from any source
 - if someone in your home dies or gets married
 - any other changes



Rights and Responsibilities

- telling your case manager when your pregnancy ends. Pregnancy ends with the birth of the baby, a miscarriage, or an abortion. You must report the end of the pregnancy within 10 days.
- 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.
- cooperating with Medicaid Eligibility Quality Control when they call or come to your home to interview you about the information you have given your case manager.

Committing fraud or abuse is against the law. You may be referred to the Medicaid and PeachCare for Kids® Fraud Control Unit. Violators may be limited to using one provider, terminated from the program or asked to reimburse the Department of Community Health for medical services provided.

Fraud is a dishonest act done on purpose. Abuse is an act that does not follow good practices.

Examples of participant fraud and abuse are:

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

You should report instances of fraud and abuse to:

Medicaid/ PeachCare for Kids® Fraud & Abuse Hotline (404) 463-7590 or toll free at (800) 533-0686 or by US Mail at:

Department of Community Health
OIG PI Section
2 Peachtree Street, NW
5th Floor
Atlanta, GA 30303



Rights and Responsibilities

Signature Page

I have received a copy of Form 297A, Rights and Responsibilities, for Benefits.

I certify, under penalty of perjury, all the information provided and everything I have told is the complete truth, as far as I know.

Margaret Simmons

Signature

07-05-2016

Date

Authorized Representative / Witness / Responsible Person

Date



Division of Family and
Children Services



Rights and Responsibilities

Georgia Department of Human Services Division of Family and Children Services Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Services and Third-Party Liability Requirements

Benefits of Child Support Services

Your help in the child support services process may be of value to you and your child because it may result in:

- Finding the absent parent.
- Legally establishing your child's paternity.
- Receipt of child support payments that may give you more money than if you receive Temporary Assistance for Needy Families (TANF).
- Acquisition of private health insurance through the absent parent.
- Acquisition of rights to future Social Security, veterans or other government benefits.

Cooperation with DFCS and DCSS

The law requires you to help the Division of Family and Children Services (DFCS) and the Division of Child Support Services (DCSS) get any support owed to you and the children for whom TANF is requested, unless you have good cause for not helping.

In helping DFCS or DCSS, you must do one or more of the following:

- Name the absent parent(s) of any child for whom you are requesting TANF or Medicaid.
- Provide information to help find the absent parent(s).
- Help determine who the legal father is if your child was born out of wedlock.
- Agree to have a blood test if the person you name as the father denies paternity.
- Help the state get money owed to you and/or the child who receives TANF.
- Provide information about medical insurance the absent parent has on your child.

You must come to the DFCS office, DCSS or court to sign papers or provide needed information.

Good Cause

You may have good cause for not wanting to help DCSS collect child support or medical coverage for your child. You may not have to help if you believe helping is not in your child's best interest, and if you can prove it. If you want to claim good cause, you must tell your worker. You can do this at any time.

If You Do Not Help and Do Not Have Good Cause

- You will not be eligible to receive TANF for yourself and your child.
- Your child may still be eligible for Medicaid.

Good Cause Reasons

You may claim good cause for any of the following reasons:

- Your help may cause serious physical or emotional harm to your child or to you.
- The child was born as a result of rape or incest.
- Court proceedings are underway for adoption of the child.
- An agency is helping you to decide whether to place the child for adoption.

To Prove Good Cause, You Must

- give DFCS information it needs to decide if you have good cause for not helping. If you fear physical harm and cannot get proof, DFCS may still be able to make a good cause determination.
- give proof to DFCS within 20 days of claiming good cause. DFCS will give you more time only if you have trouble getting proof.

DFCS may excuse you from helping based on the information you provide. Or, DFCS may ask you to provide more information. DFCS will not contact the absent parent without telling you.

NOTE: If you are applying for TANF, you will not be approved until you give DFCS proof of your claim of good cause or the information DFCS needs to investigate your claim.

Form 297A (Rev. 09/20)

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Division of Family and
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EXAMPLES OF PROOF OF GOOD CAUSE

- birth certificate, medical or law enforcement records showing that the child was born as a result of rape or incest
- court or other legal documents showing that adoption proceedings have begun
- court, medical, criminal, child protective services, social services, psychological or law enforcement records showing that the absent parent may hurt you or the child
- medical records or written statements from a mental health professional showing the history and current status of your and/or the child's emotional health
- a written statement from a public or private agency showing you are being helped to decide whether to give your child up for adoption
- sworn statements from friends, neighbors, clergy, social workers, or medical professionals who know why you have good cause.

If you need help in getting any of the documents, ask your worker.

Child Support Rules

If you receive TANF, you give the state of Georgia, by law, any rights you have to receive child support. Once the court order is established, the absent parent will be required to pay child support through DCSS. After the court order is established, you will be required to report any money you receive directly from the absent parent. You must also help establish paternity for your child and cooperate with DCSS in establishing a child support order. If you do not cooperate and do not have good cause, you may not be eligible for TANF.

If you receive TANF and the absent parent pays child support through the Division of Child Support Services (DCSS), you probably will NOT receive the full amount of the child support payment. Instead, you may receive a "gap" payment. All child support paid by an absent parent, which is in excess of the "gap" amount, is retained by DCSS and is used to pay back the TANF funds that you have received. *Your TANF case manager can explain gap budgeting and the payment procedures to you.*

If your TANF case is closed, child support payments will be sent to you up to the amount of the absent parent's current monthly obligation. Any child support amount paid over the current obligation will be kept by the state to repay past TANF grants received by you. Once the past TANF grants are repaid, you will be sent all child support paid by the absent parent.

If your TANF case is closed and then reopened, *any child support back payments due you will be assigned to the state up to the amount of all TANF money you have ever received.* When the Unreimbursed Public Assistance (UPA) is repaid, then you will start receiving any back payments owed to you.

If you receive child support payments to which you are not entitled, you may have to repay the state. The state will notify you of the amount of the overpayment and the timeframe for repayment.

DCSS may review the DFCS good cause decision in your case. If you request a hearing about the decision, DCSS may participate in the hearing.

If you have good cause for not helping, DCSS will not try to establish paternity or collect child support.

I have read this notice about my rights to claim good cause and not helping to establish paternity or to collect child support from the absent parent.



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Rights and Responsibilities

What is Domestic Violence?

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, partner, or "ex".

Your local Department of Family and Children Services wants to help you and your children stay safe.

If any of these things are happening to you, talk to your caseworker.

- ? Has your spouse, partner, boyfriend or "ex" ever hit or slapped you?
- ? Has this person ever threatened to harm you?
- ? Has this person threatened to take your children?
- ? Does the person insult you or act jealous?
- ? Do you ever feel this person is running your life or keeping you away from your family and friends, or preventing you from going to work or school?
- ? Does the person keep track of what you do, where you go or who you talk to on the phone?
- ? Does the person destroy things you own or care about?
- ? Are you afraid of this person?
- ? Is it unsafe for you to go home?

If you answered YES to any of the questions, it may be time to think about safety for you and your children.

Domestic Violence and TANF

- Some of the requirements of Temporary Assistance for Needy Families (TANF) may not apply to you.
- You can tell a DFCS caseworker anytime that your partner is being violent.
- DFCS will refer you to someone you can talk to about your situation.
- DFCS will help you with assistance, a safe place to stay for you and your children, medical and mental health care, treatment for addiction and special help for victims of crime and domestic violence.
- DFCS will not share the information with anyone outside the agency without your knowledge.
- Let DFCS know when you are no longer in a dangerous situation.

Domestic Violence can happen to ANYONE.

- ❖ Domestic violence occurs on all social and economic levels, regardless of employment or education, race, or ethnic background, religion, marital status, physical ability, age or sexual orientation.
- ❖ Each year more than 50,000 incidents of domestic violence are reported to Georgia Law Enforcement agencies.
- ❖ More than 50 percent of all women are battered by intimate partners at some time in their lives.
- ❖ A woman is physically abused every 9 seconds in this country, an estimated 2 to 4 million women annually.
- ❖ Battering is the leading cause of injury to women in the United States, more than rape, mugging or auto accidents combined.
- ❖ Nationally, 50 percent of all homeless women and children are on the streets because of violence in the home.
- ❖ Between 15 and 25 percent of pregnant women are battered.
- ❖ The Federal Bureau of Investigations (F.B.I.) estimates that only 1 in 10 incidents of domestic violence are ever reported.
- ❖ Every day, 4 women in the United States, are murdered by their intimate partner.

FOR MORE INFORMATION

Free, confidential services are available from domestic violence shelter and programs supported by the Department of Human Services.

FOR HELP 24 HOURS A DAY, CALL 1-800-334-2836

Call this toll-free number to speak to someone at your local domestic violence shelter. You can call from anywhere in the state to find a safe place to stay for you and your children and get other resources to help you.



Division of Family and
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Rights and Responsibilities

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.

Form 297A (Rev. 09/20)

A-13



Rights and Responsibilities

Nondiscrimination Statement

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

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027), found online at: <https://www.usda.gov/oasr/how-to-file-a-program-discrimination-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.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

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

This institution is an equal opportunity provider.

**GEORGIA DEPARTMENT OF HUMAN SERVICES
EXPEDITED FOOD STAMP SCREENING TOOL**

Case Name/Client ID: _____ / Screener's name/date: _____

| | | |
|---|--------------------|----|
| Verification of identification provided? | YES | NO |
| Have you made a copy of all verification provided? | YES | NO |
| Type of Interview (Phone _____ Office _____) | DATE _____ | |
| Is anyone in the HH attending college or tech school? | YES | NO |
| Has anyone been convicted of a drug felony after 8-22-96? | YES | NO |
| If an adult AU member is under age 22, who is he/she living with? | Relationship _____ | |

1. Has AU received FS this month in Georgia or another state? No-
 Yes-
2. Is any AU member currently active in a FS case or any case in another county? No-
 Yes-
3. Total Gross earned income that will be rec'd for application month _____
Employer Name _____
Employment Begin Date _____ Employment End Date _____
Rate of Pay _____ Hours Worked Weekly _____
- 4 Total Gross unearned income that will be rec'd for application month _____
Type of Unearned Income _____ Amount _____ wk/bi-wk/semi-mo/mo (circle one)
Type of Unearned Income _____ Amount _____ wk/bi-wk/semi-mo/mo (circle one)
5. Total Gross Income (Add Lines 3 & 4) _____
6. Total liquid resources (cash, checking, savings, etc) _____
7. AU's Gross Income (Line 5) is less than \$150
AND Liquid Resources (line 6) are \$100 or less No- Continue
 Yes - Expedited
8. Total Gross Income and Liquid Resources (Add Lines 5 & 6) _____
9. Monthly shelter (Do not include past due amounts or deposits)
 - A. Mortgage _____
 - B. taxes _____
 - C. Insurance _____
 - D. Rent _____
10. Total Monthly Shelter (Add amounts A through C or use amount D) _____
11. Monthly Utilities
 - A. Are you billed, or do you pay a heating or cooling expense? Mark all that apply
Electric _____ Gas _____ Window/central air conditioner _____ Kerosene oil _____ Wood _____
 Yes
 No
 - B. Have you received energy assistance in the last 12 months?
If yes, amount received \$ _____
 - C. HC SUA (\$ 367) - (For A or B)
 - D. Limited SUA (\$323)
(AU has no heating or cooling cost and has at least 2 utility bills)
 - E. Telephone only- phone standard (\$47.00) _____
12. Total Monthly Utilities (Enter amount for C, D, or E) _____
13. Total Monthly Shelter (Add Lines 10 & 12) _____
14. AU's total shelter and utility costs (line 13) exceeds Gross Income and Resources (line 8) No- Continue
 Yes - Expedited
15. Is anyone in your HH a migrant farm worker with resources less than \$100 & terminated income in the month of application? No- Continue
 Yes - Expedited





Application for Benefits

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

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

Food Stamps (Supplemental Nutrition Assistance Program (SNAP))

The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, is a federally funded program that provides monthly benefits to low-income households to help pay for the cost of food. The program also provides nutrition education to families to meet their food and nutritional needs and provides employment and training opportunities to help families gain employment that leads to less dependence on SNAP.

Temporary Assistance for Needy Families (TANF)

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

Grandparents Raising Grandchildren (GRG)

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

Refugee Cash Assistance

The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, and unaccompanied refugee minors.

Medicaid

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

Please fill out the chart below about the applicant.

| | | | |
|--|----------------------|---|--------|
| First Name Amy | Middle Initial | Last Name Brandon | Suffix |
| Street Address Where You Live 233 Boynton St | Apt | | |
| City Atlanta | State GA | Zip Code 30303 | |
| Mailing Address (If different) PO Box 8650 | | | |
| Main Telephone Number 404-555-5455 | Other Contact Number | Email Address (optional) | |
| Electronic Communication: Yes <input type="checkbox"/> or No <input type="checkbox"/> (optional) | | | |
| What is your Preferred Language? English | | If an interview is required, will you need an interpreter? Yes <input type="checkbox"/> or No <input checked="" type="checkbox"/> | |

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?



Application for Benefits

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

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. 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)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of \$3750 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.

Amy Brandon

Signature

07/05/2016

Date

Witness Signature if signed by "X"

Date

Authorized Representative:

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

Authorized Representative 1 Program Types: Food Stamps (SNAP) TANF Medical Assistance

Authorized Representative 1 Duties: Sign application on applicant's behalf

Complete and submit renewal form Receive copies of notices and other communication

Act on behalf of applicant in all other matters Receive a TANF benefit card (EPPIC)

Person Name 1: _____

Organization Name 1 (if applicable): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Yes _____ or No _____ (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): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Yes _____ or No _____ (optional) Email Address (optional) _____

Preferred Language: _____ Is an interpreter needed? Yes _____ or No _____



Application for Benefits

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 Office Use Only Date Received: _____



Application for Benefits

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

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

1. Are you or any household member a migrant or seasonal farm worker?

Yes

No

If yes, who _____

2. Total Gross earned income that will be received for this month:

\$ _____

Employer Name _____

Employment Begin Date _____ Employment End Date _____

Rate of Pay _____ Hours Worked Weekly _____

How Often Are You Paid: weekly/bi-weekly/semi-monthly/monthly (circle one)

3. Total Gross unearned income that will be received for this month:

\$ 900

Type of Unearned Income Social Security Amount _____

How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

Type of Unearned Income _____ Amount _____

How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

4. Total earned and unearned income for this month:

\$ 900

5. How much money do you and all household members have in cash or in the bank? \$ 590

6. What is the monthly amount of your rent, mortgage, property taxes, and/or homeowner's insurance? \$ 689

7. What is the total amount of your electric, water, gas, and/or other utilities this month? \$ 120

(Exclude past due and late fee amounts in the total)

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

Electric Gas _____ Window or central air conditioner _____ Kerosene oil _____ Wood _____

b. Have you received energy assistance in the last 12 months? Yes No If yes, amount received \$ _____



Application for Benefits

Tell Us about the Applicant and All Household Members

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

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

| NAME | | | Relationship | Is this person applying for benefits? | Does this person need health coverage? | Birth Date | Social Security Number (Applicants Only) | Sex (M/F) | Hispanic or Latino? (Optional) | Race Code (Optional) | Are you a U.S. citizen, U.S. national, or qualified alien/immigrant? (Applicants only) |
|--|--------|---------|--------------|---------------------------------------|--|--------------------|---|--------------|-----------------------------------|-------------------------|---|
| First | Middle | Initial | Last | (Y/N) | (Y/N) | Format (--/-/-) | | (Y/N) | | (See codes Below) | (Y/N) |
| Amy Brandon | | | SELF | Y | N | 4/09/52 | 888-02-XXX | F | N | WH | Y |
| | | | | | | | | | | | |
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| | | | | | | | | | | | |
| 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. | | | | | | | | | | | |



Application for Benefits

If you or other household applicants are not U.S. Citizens or U.S. Nationals, complete the following chart:

| NAME | | | Immigration document type | Document ID number | Have you lived in the U.S. since 1996? | Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? |
|-------|----------------|------|---------------------------|--------------------|--|--|
| First | Middle Initial | Last | | | (Y/N) | (Y/N) |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

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)

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: _____



Application for Benefits

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

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

If yes:

a. Who: _____

b. Where: _____

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

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



Application for Benefits

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, please complete the section below:

Who: _____

When: _____

- Are you in compliance with the terms of probation related to any sentence received as a result of a felony conviction? (Food Stamps (SNAP) only) Yes No
- Are you in compliance with the terms of parole related to any sentence received as a result of a felony conviction? (Food Stamps (SNAP) only) Yes No
- Have you successfully completed **all the terms of probation or parole** related to any felony related conviction? (Food Stamps (SNAP)) 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: _____

Tell Us about the Applicant and All Household Members Income

Do you or anyone you are applying for receive any type of income such as: wages, tips, bonuses, self-employment, Social Security/Railroad Retirement, other disability, pensions, unemployment, or any other income? For Food Stamps (SNAP) and TANF, please also list income such as: VA income, child support, money from other people or workers compensation. If yes, complete the chart below.

| Household Member Name with Income | Type of Income | Employer Name /Source of Income | Monthly Amount (Before Deductions) | How Often received (monthly, biweekly, weekly) | Pay Per Hour | Hours per Week | DATE (S) PAID |
|-----------------------------------|-----------------|---------------------------------|------------------------------------|--|--------------|----------------|---------------|
| Amy | social security | SSA | \$900 | monthly | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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



Application for Benefits

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

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

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

| | | | |
|-----------------------------------|--|-----------------------------------|--|
| Checking Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Funeral Plans/Prepaid Burial Item | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Savings Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Burial Plots or Contracts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Government Bonds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stocks and Bonds | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Trust Funds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (IRA, CD, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Real Property/Homeplace Property? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

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

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

| Household Member Name with Resource | Type of Resource | Account/Policy Number | Value | Name of Bank, Insurance Company, etc. |
|-------------------------------------|------------------|-----------------------|-------|---------------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you or your spouse own a vehicle? If so, please describe below. Yes No

| Household Member Who Owns Vehicle | Vehicle Make | Model | Year | Amount Owed |
|-----------------------------------|--------------|-------|------|-------------|
| | | | | |
| | | | | |
| | | | | |

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

If yes, please complete the following information.

| Policy Owner | Insurance Company | Policy Number | Face Value | Cash Value |
|--------------|-------------------|---------------|------------|------------|
| | | | | |
| | | | | |

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

Do you pay for the care of a dependent child or a disabled adult household member? Yes No If yes, complete the chart below.

| Person who requires care | Person who pays for care | Reason for care | Provider's Name/Number | Amount paid to Provider | How often paid |
|--------------------------|--------------------------|-----------------|------------------------|-------------------------|----------------|
| | | | | | |
| | | | | | |



Application for Benefits

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: _____

Does anyone in the household pay child support to someone living outside of the home? Yes No

If yes, complete the chart below.

| Household Member Obligated to Pay | Name of Child for Whom Support is paid | Obligated Amount to Pay | Actual Amount Paid | To Whom is Child Support Paid? |
|-----------------------------------|--|-------------------------|--------------------|--------------------------------|
| | | | | |
| | | | | |

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

Does anyone 60 years of age or older or disabled have medical expenses? Yes No If yes, complete the chart below.

| Household Member Who Has Expense | Type of Expense (doctor visits, hospital visit, prescriptions, Medicare or health Insurance premiums, glasses) | Amount Owed | Still Owed? Yes/No | Date Paid | Will Insurance Pay? Yes/No |
|----------------------------------|--|-------------|--------------------|-----------|----------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Does anyone 60 years of age or older or disabled have medical expenses for transportation? Yes No

If yes, complete chart below.

| Purpose of the trip (doctor or hospital visit; pharmacy pick-up) | Total miles driven: | Cost of taxi, bus, parking or lodging: |
|--|---------------------|--|
| | | |
| | | |

Do you or any household member have shelter and utility expenses? Yes No If yes, complete the chart below.

| Expense | Amount | How Often? | Who paid? |
|--------------------|--------|------------|-----------|
| Rent/Mortgage | \$689 | monthly | Amy |
| Property Taxes | | | |
| Property Insurance | | | |
| Electricity | \$100 | monthly | Amy |
| Gas | | | |
| Garbage | | | |
| Telephone | \$20 | monthly | Amy |
| Other | | | |



Application for Benefits

Do you share monthly household expenses with anyone in the home? Yes No

If yes, who? _____

Comments/Documentation _____

Paid to whom _____ Amount paid \$ _____ per _____

Landlord's Name _____

Landlord's address: _____

Does someone else pay any of these household bills for you? Yes No If yes, complete the chart below:

| | |
|----------------------|---|
| Who pays the bill? | What bills are paid? |
| What amount is paid? | To whom does this person pay the bills? |

Please complete the following information if applying for Medicaid.

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? Yes No

If yes, who? (list each person who plans to file) _____

2. Will any of the tax filers listed file jointly with a spouse? Yes No If yes, please list spouse's name: _____

3. Will any of the tax filers claim any dependents on their tax return? Yes No If yes, please list name(s) of dependents _____

4. Will anyone be claimed as a dependent on someone else's tax return? Yes No If yes, please list the name of the tax filer and the dependent: (Filer) _____

(Dependent) _____

How is the tax dependent related to the tax filer? _____

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

Alimony paid \$ _____ How often? _____ Student loan interest \$ _____ How often? _____

Other deductions \$ _____ How often? _____ Type: _____

Other health coverage

1. Does anyone have other health insurance that covers anyone in your household? Yes No

If you answered yes to question 4 above, please complete the following information and Attachment A:

| Name of Policy holder | Health Insurance Company Name, Address and Telephone Number | Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical) | Name of Persons Covered | Effective Date | Policy Number |
|-----------------------|---|--|-------------------------|----------------|---------------|
| | | | | | |
| | | | | | |

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

Yes No If yes, you need to complete Attachment A.

Is this a state employee benefit plan? Yes No



Application for Benefits

3. Have you or anyone listed on this application lost any health coverage in the last 2 months?
 - a. Yes If yes, why was it lost? _____
 - b. No
4. Was anyone in Foster Care at age 18 applying for Medicaid? Yes No
5. Is anyone in your household American or Alaska Native? Yes No
If yes, complete Attachment B.

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

1. Is anyone applying for health coverage blind or disabled?
 Yes No If yes, please list name _____
2. Are you or your spouse currently covered by Medicare?
 Yes No If yes, please list name _____
3. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?
 Yes No If yes, date of SSI application: _____
4. Are you applying for someone who is now deceased and has unpaid medical bills within the last three (3) months?
 Yes No
5. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
 Yes No
6. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?
 Yes No
7. Are you applying for Medicaid to help pay for community-based waiver services such as Community Care Services, NOW/COMP, Hospice Care, Independent Care Waiver, or the Deeming Waiver (Katie Beckett)?
 Yes No



Application for Benefits

Food Stamp (SNAP) Program Penalties

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

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

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

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

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

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

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

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

TANF Program Penalties

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

- Any household member who hides information and does not report changes on time or does not tell the truth will lose TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation. The misuse of the cash assistance funds or TANF DEBIT card to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities "strip clubs", poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, race tracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons is strictly prohibited and will result in a loss of TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member hiding information or you do not report changes on time or do not tell the truth and are convicted, you may not get TANF for 6 months for the first violation, 12 months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member guilty of giving false information about where you live so you can receive benefits in more than one state, you will be barred for 10 years.
- If a court convicted you of a drug-related charge, controlled substance, or a serious violent felony on or after 1/1/1997, you or that household member will not be eligible and/or permanently disqualified.



Application for Benefits

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

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. 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)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of \$3750 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.

Amy Brandon

Applicant's Signature

07/05/2016

Date

Authorized Representative's Signature

Date

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.



Application for Benefits

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

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

Food Stamps (Supplemental Nutrition Assistance Program (SNAP))

The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, is a federally funded program that provides monthly benefits to low-income households to help pay for the cost of food. The program also provides nutrition education to families to meet their food and nutritional needs and provides employment and training opportunities to help families gain employment that leads to less dependence on SNAP.

Temporary Assistance for Needy Families (TANF)

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

Grandparents Raising Grandchildren (GRG)

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

Refugee Cash Assistance

The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, and unaccompanied refugee minors.

Medicaid

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

Please fill out the chart below about the applicant.

| | | | |
|--|---|----------------------------|--------|
| First Name Selena | Middle Initial | Last Name Harrod | Suffix |
| Street Address Where You Live 766 Old Atlanta Rd | Apt | | |
| City Fairburn | State GA | Zip Code 30265 | |
| Mailing Address (If different) | | | |
| Main Telephone Number 404-555-3569 | Other Contact Number | Email Address (optional) | |
| Electronic Communication: Yes <input type="checkbox"/> or No <input type="checkbox"/> (optional) | | | |
| What is your Preferred Language? English | If an interview is required, will you need an interpreter? Yes <input type="checkbox"/> or No <input checked="" type="checkbox"/> | | |

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?



Application for Benefits

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

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. 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)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of \$3750 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.

Selena Harrod

Signature

07/05/2016

Date

Witness Signature if signed by "X"

Date

Authorized Representative:

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

Authorized Representative 1 Program Types: Food Stamps (SNAP) TANF Medical Assistance

Authorized Representative 1 Duties: Sign application on applicant's behalf

Complete and submit renewal form Receive copies of notices and other communication

Act on behalf of applicant in all other matters Receive a TANF benefit card (EPPIC)

Person Name 1: _____

Organization Name 1 (if applicable): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Yes _____ or No _____ (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): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Yes _____ or No _____ (optional) Email Address (optional) _____

Preferred Language: _____ Is an interpreter needed? Yes _____ or No _____



Application for Benefits

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 Office Use Only Date Received: _____



Application for Benefits

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

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

1. Are you or any household member a migrant or seasonal farm worker?

Yes

No

If yes, who _____

2. Total Gross earned income that will be received for this month:

\$ 1400

Employer Name Petsmart

Employment Begin Date 2-15-16 Employment End Date _____

Rate of Pay \$8.50 Hours Worked Weekly 40

How Often Are You Paid: weekly/bi-weekly/semi-monthly/monthly (circle one)

3. Total Gross unearned income that will be received for this month:

\$ _____

Type of Unearned Income _____ Amount _____

How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

Type of Unearned Income _____ Amount _____

How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

4. Total earned and unearned income for this month:

\$ 1400

5. How much money do you and all household members have in cash or in the bank? \$ 0

6. What is the monthly amount of your rent, mortgage, property taxes, and/or homeowner's insurance? \$ 400

7. What is the total amount of your electric, water, gas, and/or other utilities this month? \$ 125

(Exclude past due and late fee amounts in the total)

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

Electric Gas _____ Window or central air conditioner _____ Kerosene oil _____ Wood _____

b. Have you received energy assistance in the last 12 months? Yes • No If yes, amount received \$ _____



Application for Benefits

Tell Us about the Applicant and All Household Members

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

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

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.

| NAME First Middle Initial Last | Relationship | Is this person applying for benefits? (Y/N) | Does this person need health coverage? (Y/N) | Birth Date Format (--/-/-) | Social Security Number (Applicants Only) | Sex (M/F) | Hispanic or Latino? (Optional) | Race Code (Optional) | Are you a U.S. citizen, U.S. national, or qualified alien/immigrant? (Applicants only) (See codes Below) (Y/N) |
|---|--------------|--|---|----------------------------------|---|--------------|-----------------------------------|-------------------------|---|
| Selena Harrod | SELF | Y | N | 4/09/92 | 111-02-XXX | F | N | WH | Y |
| Mazie Harrod | daughter | Y | N | 5/15/14 | 222-02-XXX | F | N | WH | Y |
| Jessie Harrod | daughter | Y | N | 5/31/16 | 333-02-XXX | F | N | WH | Y |
| Nancy Daughtry | mom | N | N | 8/25/65 | 444-02-XXX | F | N | WH | Y |
| Craig Daughtry | brother | N | N | 1/18/89 | 555-02-XXX | M | N | WH | Y |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

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.



Application for Benefits

If you or other household applicants are not U.S. Citizens or U.S. Nationals, complete the following chart:

| First | Middle Initial | Last | NAME Immigration document type | Document ID number | Have you lived in the U.S. since 1996? (Y/N) | Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? (Y/N) |
|-------|----------------|------|-----------------------------------|--------------------|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

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)
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: _____



Application for Benefits

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

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

If yes:

a. Who: _____

b. Where: _____

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

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



Application for Benefits

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, please complete the section below:

Who: _____

When: _____

- Are you in compliance with the terms of probation related to any sentence received as a result of a felony conviction? (Food Stamps (SNAP) only) Yes No
- Are you in compliance with the terms of parole related to any sentence received as a result of a felony conviction? (Food Stamps (SNAP) only) Yes No
- Have you successfully completed all the terms of probation or parole related to any felony related conviction? (Food Stamps (SNAP)) 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: _____

Tell Us about the Applicant and All Household Members Income

Do you or anyone you are applying for receive any type of income such as: wages, tips, bonuses, self-employment, Social Security/Railroad Retirement, other disability, pensions, unemployment, or any other income? For Food Stamps (SNAP) and TANF, please also list income such as: VA income, child support, money from other people or workers compensation. If yes, complete the chart below.

| Household Member Name with Income | Type of Income | Employer Name /Source of Income | Monthly Amount (Before Deductions) | How Often received (monthly, biweekly, weekly) | Pay Per Hour | Hours per Week | DATE (S) PAID |
|-----------------------------------|----------------|---------------------------------|------------------------------------|--|--------------|----------------|---------------|
| Selena | wages | Petsmart | \$1400 | weekly | \$10 | 20 | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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



Application for Benefits

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

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

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

| | | | |
|-----------------------------------|--|-----------------------------------|--|
| Checking Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Funeral Plans/Prepaid Burial Item | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Savings Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Burial Plots or Contracts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Government Bonds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stocks and Bonds | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Trust Funds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (IRA, CD, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Real Property/Homeplace Property? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

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

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

| Household Member Name with Resource | Type of Resource | Account/Policy Number | Value | Name of Bank, Insurance Company, etc. |
|-------------------------------------|------------------|-----------------------|-------|---------------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you or your spouse own a vehicle? If so, please describe below. Yes No

| Household Member Who Owns Vehicle | Vehicle Make | Model | Year | Amount Owed |
|-----------------------------------|--------------|-------|------|-------------|
| | | | | |
| | | | | |
| | | | | |

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

If yes, please complete the following information.

| Policy Owner | Insurance Company | Policy Number | Face Value | Cash Value |
|--------------|-------------------|---------------|------------|------------|
| | | | | |
| | | | | |

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

Do you pay for the care of a dependent child or a disabled adult household member? Yes No If yes, complete the chart below.

| Person who requires care | Person who pays for care | Reason for care | Provider's Name/Number | Amount paid to Provider | How often paid |
|--------------------------|--------------------------|-----------------|------------------------|-------------------------|----------------|
| | | | | | |
| | | | | | |



Application for Benefits

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: _____

Does anyone in the household pay child support to someone living outside of the home? Yes No

If yes, complete the chart below.

| Household Member Obligated to Pay | Name of Child for Whom Support is paid | Obligated Amount to Pay | Actual Amount Paid | To Whom is Child Support Paid? |
|-----------------------------------|--|-------------------------|--------------------|--------------------------------|
| | | | | |
| | | | | |

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

Does anyone 60 years of age or older or disabled have medical expenses? Yes No If yes, complete the chart below.

| Household Member Who Has Expense | Type of Expense (doctor visits, hospital visit, prescriptions, Medicare or health Insurance premiums, glasses) | Amount Owed | Still Owed? Yes/No | Date Paid | Will Insurance Pay? Yes/No |
|----------------------------------|--|-------------|--------------------|-----------|----------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

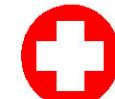
Does anyone 60 years of age or older or disabled have medical expenses for transportation? Yes No

If yes, complete chart below.

| Purpose of the trip (doctor or hospital visit; pharmacy pick-up) | Total miles driven: | Cost of taxi, bus, parking or lodging: |
|--|---------------------|--|
| | | |
| | | |

Do you or any household member have shelter and utility expenses? Yes No If yes, complete the chart below.

| Expense | Amount | How Often? | Who paid? |
|--------------------|--------|------------|-----------|
| Rent/Mortgage | \$400 | monthly | Selena |
| Property Taxes | | | |
| Property Insurance | | | |
| Electricity | \$100 | monthly | Selena |
| Gas | | | |
| Garbage | | | |
| Telephone | \$25 | monthly | Selena |
| Other | | | |



Application for Benefits

Do you share monthly household expenses with anyone in the home? Yes No

If yes, who? _____

Comments/Documentation _____

Paid to whom _____ Amount paid \$ _____ per _____

Landlord's Name _____

Landlord's address: _____

Does someone else pay any of these household bills for you? Yes No If yes, complete the chart below:

| | |
|----------------------|---|
| Who pays the bill? | What bills are paid? |
| What amount is paid? | To whom does this person pay the bills? |

Please complete the following information if applying for Medicaid.

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? Yes No

If yes, who? (list each person who plans to file) _____

2. Will any of the tax filers listed file jointly with a spouse? Yes No If yes, please list spouse's name: _____

3. Will any of the tax filers claim any dependents on their tax return? Yes No If yes, please list name(s) of dependents _____

4. Will anyone be claimed as a dependent on someone else's tax return? Yes No If yes, please list the name of the tax filer and the dependent: (Filer) _____

(Dependent) _____

How is the tax dependent related to the tax filer? _____

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

Alimony paid \$ _____ How often? _____ Student loan interest \$ _____ How often? _____
 Other deductions \$ _____ How often? _____ Type: _____

Other health coverage

1. Does anyone have other health insurance that covers anyone in your household? Yes No

If you answered yes to question 4 above, please complete the following information and Attachment A:

| Name of Policy holder | Health Insurance Company Name, Address and Telephone Number | Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical) | Name of Persons Covered | Effective Date | Policy Number |
|-----------------------|---|--|-------------------------|----------------|---------------|
| | | | | | |
| | | | | | |

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

Yes No If yes, you need to complete Attachment A.

Is this a state employee benefit plan? Yes No



Application for Benefits

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

a. Yes If yes, why was it lost? _____
b. No

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

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

If yes, complete Attachment B.

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

1. Is anyone applying for health coverage blind or disabled?

Yes No If yes, please list name _____

2. Are you or your spouse currently covered by Medicare?

Yes No If yes, please list name _____

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

Yes No If yes, date of SSI application: _____

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

Yes No

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

Yes No

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

Yes No

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

Yes No



Application for Benefits

Food Stamp (SNAP) Program Penalties

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

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

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

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

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

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

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

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

TANF Program Penalties

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

- Any household member who hides information and does not report changes on time or does not tell the truth will lose TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation. The misuse of the cash assistance funds or TANF DEBIT card to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities "strip clubs", poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, race tracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons is strictly prohibited and will result in a loss of TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member hiding information or you do not report changes on time or do not tell the truth and are convicted, you may not get TANF for 6 months for the first violation, 12 months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member guilty of giving false information about where you live so you can receive benefits in more than one state, you will be barred for 10 years.
- If a court convicted you of a drug-related charge, controlled substance, or a serious violent felony on or after 1/1/1997, you or that household member will not be eligible and/or permanently disqualified.



Application for Benefits

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

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. 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)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of \$3750 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.

Selena Harrad

07-05-16

Applicant's Signature

Date

Authorized Representative's Signature

Date

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.



Rights and Responsibilities

Signature Page

I have received a copy of Form 297A, Rights and Responsibilities, for Benefits.

I certify, under penalty of perjury, all the information provided and everything I have told is the complete truth, as far as I know.

Selena Harrod

Signature

07-05-2016

Date

Authorized Representative / Witness / Responsible Person

Date



Application for Benefits

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

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

Food Stamps (Supplemental Nutrition Assistance Program (SNAP))

The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, is a federally funded program that provides monthly benefits to low-income households to help pay for the cost of food. The program also provides nutrition education to families to meet their food and nutritional needs and provides employment and training opportunities to help families gain employment that leads to less dependence on SNAP.

Temporary Assistance for Needy Families (TANF)

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

Grandparents Raising Grandchildren (GRG)

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

Refugee Cash Assistance

The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, and unaccompanied refugee minors.

Medicaid

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

Please fill out the chart below about the applicant.

| | | | |
|--|----------------------|---|--------|
| First Name Jennifer | Middle Initial | Last Name Gonzales | Suffix |
| Street Address Where You Live 9954 E. Rockhouse Road | Apt | | |
| City Senoia | State GA | Zip Code 30276 | |
| Mailing Address (If different) PO Box 5968 | | | |
| Main Telephone Number 404-555-8597 | Other Contact Number | Email Address (optional) | |
| Electronic Communication: Yes <input type="checkbox"/> or No <input type="checkbox"/> (optional) | | | |
| What is your Preferred Language? English | | If an interview is required, will you need an interpreter? Yes <input type="checkbox"/> or No <input checked="" type="checkbox"/> | |

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?



Application for Benefits

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

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. 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)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of \$3750 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.

Jennifer Gonzales

Signature

07/05/2016

Date

Witness Signature if signed by "X"

Date

Authorized Representative:

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

Authorized Representative 1 Program Types: Food Stamps (SNAP) TANF Medical Assistance

Authorized Representative 1 Duties: Sign application on applicant's behalf

Complete and submit renewal form Receive copies of notices and other communication

Act on behalf of applicant in all other matters Receive a TANF benefit card (EPPIC)

Person Name 1: _____

Organization Name 1 (if applicable): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Yes _____ or No _____ (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): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Yes _____ or No _____ (optional) Email Address (optional) _____

Preferred Language: _____ Is an interpreter needed? Yes _____ or No _____



Application for Benefits

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 Office Use Only Date Received: _____



Application for Benefits

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

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

1. Are you or any household member a migrant or seasonal farm worker?

Yes

No

If yes, who _____

2. Total Gross earned income that will be received for this month:

Employer Name Self

\$ 300

Employment Begin Date _____

Employment End Date _____

Rate of Pay _____

Hours Worked Weekly _____

How Often Are You Paid: weekly/bi-weekly/semi-monthly/monthly (circle one)

3. Total Gross unearned income that will be received for this month:

Type of Unearned Income _____ Amount _____

\$ _____

How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

Type of Unearned Income _____ Amount _____

How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

4. Total earned and unearned income for this month:

\$ 300

5. How much money do you and all household members have in cash or in the bank? \$ 50

6. What is the monthly amount of your rent, mortgage, property taxes, and/or homeowner's insurance? \$ 200

7. What is the total amount of your electric, water, gas, and/or other utilities this month? \$ 50

(Exclude past due and late fee amounts in the total)

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

Electric Gas Window or central air conditioner Kerosene oil Wood

b. Have you received energy assistance in the last 12 months? Yes No If yes, amount received \$ _____



Application for Benefits

Tell Us about the Applicant and All Household Members

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

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

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.

| NAME | | | Relationship | Is this person applying for benefits? | Does this person need health coverage? | Birth Date | Social Security Number | Sex | Hispanic or Latino? | Race Code | Are you a U.S. citizen, U.S. national, or qualified alien/immigrant? (Applicants only) |
|--|----------------|------|--------------|---------------------------------------|--|-------------------|------------------------|----------|---------------------|------------|--|
| First | Middle Initial | Last | | (Y/N) | (Y/N) | Format (--/--/--) | (Applicants Only) | (M/F) | (Optional) | (Optional) | (See codes Below) |
| <i>Jenninfer Gonzales</i> | | | SELF | <i>Y</i> | <i>N</i> | <i>4/02/90</i> | | <i>F</i> | <i>Y</i> | <i>WH</i> | <i>N</i> |
| <i>Max Gonzales</i> | | | son | <i>Y</i> | <i>N</i> | <i>1/17/10</i> | <i>678-02-XXX</i> | <i>M</i> | <i>Y</i> | <i>WH</i> | <i>Y</i> |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| 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. | | | | | | | | | | | |



Application for Benefits

If you or other household applicants are not U.S. Citizens or U.S. Nationals, complete the following chart:

| First | Middle Initial | Last | NAME | Immigration document type | Document ID number | Have you lived in the U.S. since 1996? | Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? |
|-------|----------------|------|------|---------------------------|--------------------|--|--|
| | | | | | | (Y/N) | (Y/N) |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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)
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: _____



Application for Benefits

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

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

If yes:

a. Who: _____

b. Where: _____

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

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



Application for Benefits

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, please complete the section below:

Who: _____

When: _____

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

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

Tell Us about the Applicant and All Household Members Income

Do you or anyone you are applying for receive any type of income such as: wages, tips, bonuses, self-employment, Social Security/Railroad Retirement, other disability, pensions, unemployment, or any other income? For Food Stamps (SNAP) and TANF, please also list income such as: VA income, child support, money from other people or workers compensation. If yes, complete the chart below.

| Household Member Name with Income | Type of Income | Employer Name /Source of Income | Monthly Amount (Before Deductions) | How Often received (monthly, biweekly, weekly) | Pay Per Hour | Hours per Week | DATE (S) PAID |
|-----------------------------------|----------------|---------------------------------|------------------------------------|--|--------------|----------------|---------------|
| Jennifer | wages | self employed | \$1400 monthly | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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



Application for Benefits

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

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

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

| | | | |
|-----------------------------------|--|-----------------------------------|--|
| Checking Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Funeral Plans/Prepaid Burial Item | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Savings Accounts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Burial Plots or Contracts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Government Bonds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stocks and Bonds | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Trust Funds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (IRA, CD, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Real Property/Homeplace Property? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

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

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

| Household Member Name with Resource | Type of Resource | Account/Policy Number | Value | Name of Bank, Insurance Company, etc. |
|-------------------------------------|------------------|-----------------------|-------|---------------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you or your spouse own a vehicle? If so, please describe below. Yes No

| Household Member Who Owns Vehicle | Vehicle Make | Model | Year | Amount Owed |
|-----------------------------------|--------------|-------|------|-------------|
| | | | | |
| | | | | |
| | | | | |

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

If yes, please complete the following information.

| Policy Owner | Insurance Company | Policy Number | Face Value | Cash Value |
|--------------|-------------------|---------------|------------|------------|
| | | | | |
| | | | | |

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

Do you pay for the care of a dependent child or a disabled adult household member? Yes No If yes, complete the chart below.

| Person who requires care | Person who pays for care | Reason for care | Provider's Name/Number | Amount paid to Provider | How often paid |
|--------------------------|--------------------------|-----------------|------------------------|-------------------------|----------------|
| | | | | | |
| | | | | | |



Application for Benefits

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: _____

Does anyone in the household pay child support to someone living outside of the home? Yes No

If yes, complete the chart below.

| Household Member Obligated to Pay | Name of Child for Whom Support is paid | Obligated Amount to Pay | Actual Amount Paid | To Whom is Child Support Paid? |
|-----------------------------------|--|-------------------------|--------------------|--------------------------------|
| | | | | |
| | | | | |

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

Does anyone 60 years of age or older or disabled have medical expenses? Yes No If yes, complete the chart below.

| Household Member Who Has Expense | Type of Expense (doctor visits, hospital visit, prescriptions, Medicare or health insurance premiums, glasses) | Amount Owed | Still Owed? Yes/No | Date Paid | Will Insurance Pay? Yes/No |
|----------------------------------|--|-------------|--------------------|-----------|----------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

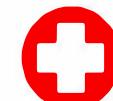
Does anyone 60 years of age or older or disabled have medical expenses for transportation? Yes No

If yes, complete chart below.

| Purpose of the trip (doctor or hospital visit; pharmacy pick-up) | Total miles driven: | Cost of taxi, bus, parking or lodging: |
|--|---------------------|--|
| | | |
| | | |

Do you or any household member have shelter and utility expenses? Yes No If yes, complete the chart below.

| Expense | Amount | How Often? | Who paid? |
|--------------------|--------|------------|-----------|
| Rent/Mortgage | \$200 | monthly | Jenninfer |
| Property Taxes | | | |
| Property Insurance | | | |
| Electricity | \$50 | monthly | Jenninfer |
| Gas | | | |
| Garbage | | | |
| Telephone | | | |
| Other | | | |



Application for Benefits

Do you share monthly household expenses with anyone in the home? Yes No

If yes, who? _____

Comments/Documentation _____

Paid to whom _____ Amount paid \$ _____ per _____

Landlord's Name _____

Landlord's address: _____

Does someone else pay any of these household bills for you? Yes No If yes, complete the chart below:

| | |
|----------------------|---|
| Who pays the bill? | What bills are paid? |
| What amount is paid? | To whom does this person pay the bills? |

Please complete the following information if applying for Medicaid.

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? Yes No

If yes, who? (list each person who plans to file) _____

2. Will any of the tax filers listed file jointly with a spouse? Yes No If yes, please list spouse's name: _____

3. Will any of the tax filers claim any dependents on their tax return? Yes No If yes, please list name(s) of dependents _____

4. Will anyone be claimed as a dependent on someone else's tax return? Yes No If yes, please list the name of the tax filer and the dependent: (Filer) _____

(Dependent) _____

How is the tax dependent related to the tax filer? _____

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

Alimony paid \$ _____ How often? _____ Student loan interest \$ _____ How often? _____

Other deductions \$ _____ How often? _____ Type: _____

Other health coverage

1. Does anyone have other health insurance that covers anyone in your household? Yes No

If you answered yes to question 4 above, please complete the following information and Attachment A:

| Name of Policy holder | Health Insurance Company Name, Address and Telephone Number | Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical) | Name of Persons Covered | Effective Date | Policy Number |
|-----------------------|---|--|-------------------------|----------------|---------------|
| | | | | | |
| | | | | | |

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

Yes No If yes, you need to complete Attachment A.

Is this a state employee benefit plan? Yes No



Application for Benefits

3. Have you or anyone listed on this application lost any health coverage in the last 2 months?
 - a. Yes If yes, why was it lost? _____
 - b. No
4. Was anyone in Foster Care at age 18 applying for Medicaid? Yes No
5. Is anyone in your household American or Alaska Native? Yes No
If yes, complete Attachment B.

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

1. Is anyone applying for health coverage blind or disabled?
 Yes No If yes, please list name _____
2. Are you or your spouse currently covered by Medicare?
 Yes No If yes, please list name _____
3. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?
 Yes No If yes, date of SSI application: _____
4. Are you applying for someone who is now deceased and has unpaid medical bills within the last three (3) months?
 Yes No
5. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
 Yes No
6. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?
 Yes No
7. Are you applying for Medicaid to help pay for community-based waiver services such as Community Care Services, NOW/COMP, Hospice Care, Independent Care Waiver, or the Deeming Waiver (Katie Beckett)?
 Yes No



Application for Benefits

Food Stamp (SNAP) Program Penalties

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

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

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

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

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

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

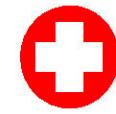
If a court of law finds you or any household member guilty of having trafficked benefits for an aggregate amount of \$500 or more, you or that household member will be permanently ineligible to participate in the Food Stamp (SNAP) Program upon the first offense of this violation.

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

TANF Program Penalties

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

- Any household member who hides information and does not report changes on time or does not tell the truth will lose TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation. The misuse of the cash assistance funds or TANF DEBIT card to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities "strip clubs", poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, race tracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons is strictly prohibited and will result in a loss of TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member hiding information or you do not report changes on time or do not tell the truth and are convicted, you may not get TANF for 6 months for the first violation, 12 months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member guilty of giving false information about where you live so you can receive benefits in more than one state, you will be barred for 10 years.
- If a court convicted you of a drug-related charge, controlled substance, or a serious violent felony on or after 1/1/1997, you or that household member will not be eligible and/or permanently disqualified.



Application for Benefits

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

I declare under penalty of perjury to the best of my knowledge that all of the information provided on this application is true and correct. 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)/Medicaid and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of \$3750 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.

Jennifer Gonzales

07-05-16

Applicant's Signature

Date _____

Authorized Representative's Signature

Date _____

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.



Rights and Responsibilities

Signature Page

I have received a copy of Form 297A, Rights and Responsibilities, for Benefits.

I certify, under penalty of perjury, all the information provided and everything I have told is the complete truth, as far as I know.

Jennifer Gonzales

Signature

07-05-2016

Date

Authorized Representative / Witness / Responsible Person

Date