

This package includes the printed material that you will need for the Food Stamps Renewal Course. It is 12 pages, and includes the following:

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Georgia Department of Human Services
FOOD STAMP/MEDICAID/TANF Renewal Form

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the *Food and Nutrition Act of 2008* and USDA policy, discrimination is also prohibited on the basis of religion or political beliefs. To file a complaint of discrimination, you may contact USDA or HHS.

Write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish)

Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C., 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY).

USDA and HHS are equal opportunity providers and employers. You may also file a complaint of Discrimination by contacting the DFCS Civil Rights Program, 2 Peachtree Street, N.W., Suite 19-248, Atlanta, Georgia 30303 or call (404) 657-3735 or fax (404) 463-3978.

Under the Department of Community Health (DCH) policy, the Medicaid program 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) (toll free) 800-533-0686.

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

Caretaker	A parent, relative or legal guardian who applies for and receives TANF with children in his or her care.
Grantee Relative	A parent, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children.
Payee	An individual who applies for or receives Medicaid only on behalf of a minor child(ren) and whose income and resources are not included in the determining the child(ren)'s eligibility.
Disqualified	The action taken to remove an individual from a Food Stamp 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 or TANF. Individuals receiving assistance are issued an EBT debit card, which is used to withdraw cash benefits and to access their food stamp accounts.
Household Members	Individuals who live in your home.
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
Gross Income	A person's total income before taking taxes or other deductions into account
Resources	Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance

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Trafficking	Selling or trading Food Stamp benefits for profit
Qualified Alien/Immigrant	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: a person lawfully admitted for permanent residence (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 granted asylum 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 granted <i>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; battered immigrants who meet the conditions set forth in section 431 (c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended. <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).
Applicant	An individual who applies for public assistance/benefits
Non-applicant	An Individual who does NOT apply for public assistance/benefits; non-applicants are not required to provide a Social Security Number (SSN), or verify citizenship/immigration status.
Assistance Unit (AU)	An assistance unit includes <i>eligible</i> individuals who live together and receive public assistance/benefits.

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FOOD STAMP/MEDICAID/TANF Renewal Form**

If you need help filling out this application or assistance communicating with us, ask us or call 1-877-423-4746. If you have a hearing impairment, call GA Relay at 1-800-255-0135. Our services are free.

For Office Use only: Date Received _____ Load # _____ Client ID # _____
Date Initiated: _____ Programs Initiated: ☐ TANF ☐ Food Stamps ☐ Medicaid

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

Please PRINT the name and address of the person who is applying/reapplying for or recertifying/renewing for benefits in the space below:

Client Name: Marcus Combs	Date of Birth: 5/15/1975	Social Security Number: 125695847
Street Address: 1965 Briarcliff Road, Apartment 6E Atlanta, GA 30314		
Mailing Address:		
Daytime Phone Number: 404-555-5569	Other Contact Number:	E-mail Address
Signature <i>Marcus Combs</i>		Date <i>10/5/XX</i>
Witness Signature if signed by 'X'		Date

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If you need help filling out this application or assistance communicating with us, ask us or call 1-877-423-4746. If you have a hearing impairment, call GA Relay at 1-800-255-0135. Our services are free.

COMMUNITY OUTREACH SERVICES: For more information about other DHS services, please visit our website at www.dfcs.dhr.georgia.gov or call 1-877-423-4746.

Please answer all questions and provide proof of all income and any expenses as requested.

HOUSEHOLD SIZE: Please fill out the chart below about the yourself or the applicant/recipient 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 your and your household members social security number(s). If anyone in your household does not want to give us information about his or her citizenship, immigration status, or social security numbers, then that person can be designated as a non-applicant. This means that the person will not be considered an applicant and will not be eligible for benefits. However, 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 SSN. Unless you are applying for or renewing Medicaid benefits as a Payee only, you will still need to tell us about your income and resources to determine the eligibility and benefit level of the household. Individuals will not be reported to the United States Citizenship and Immigration Services if they do not give us their citizenship or immigration status.

First Name	M I	Last Name	Ethnicity Hispanic or Latino? (Optional)	Race (optional)	Sex M/F	Date of Birth Format (-/-/-)	Relation To You	Is this person applying for benefits?	Social Security Number (applicants only)	Are you a U. S. Citizen or Qualified Immigrant or in a satisfactory immigration status? (applicants only)	Does the mother of this child live in the home?	Does the father of this child live in the home?	Want Medicaid?
Marcus		Combs	Y(N)		M	5/15/75	SELF	Y(N)	125695847	Y(N)	Y(N)	Y(N)	Y(N)
Sarah		Combs	Y(N)		F	6/20/78	WIFE	Y(N)	125695848	Y(N)	Y(N)	Y(N)	Y(N)
Braden		Combs	Y(N)		M	5/12/99	SON	Y(N)	125695849	Y(N)	Y(N)	Y(N)	Y(N)
George		Combs	Y(N)		M	7/26/03	SON	Y(N)	125695850	Y(N)	Y(N)	Y(N)	Y(N)
			Y/N				/	Y/N		Y/N	Y/N	Y/N	Y/N
			Y/N					Y/N		Y/N	Y/N	Y/N	Y/N
			Y/N					Y/N		Y/N	Y/N	Y/N	Y/N
			Y/N					Y/N		Y/N	Y/N	Y/N	Y/N

Race Codes (Choose all that apply):

AI – American Indian/Alaska Native

AS – Asian

BL – Black/African American

HP – Native Hawaiian/Pacific Islander

WH – White

By providing Race Codes/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.

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For Food Stamps and TANF only - STUDENTS IN HIGHER EDUCATION: Is anyone in your household enrolled at least half-time in a college, university, vocational or technical school? Yes ☐ No ☒ If yes, who: _____

School Name: _____ Grade/Status _____ Graduation date: _____

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

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

DISQUALIFICATIONS: (For Food Stamps and TANF only)

(1) Is anyone in your household disqualified? Yes ☐ No ☒

If yes, Who: _____

Reason(s) for disqualification: _____

(2) Has anyone been convicted of a drug-related felony? Yes ☐ No ☒

If yes, Who: _____

Date of offense: _____ Date of Conviction: _____

1st Offender Status? Yes ☐ No ☐

(3) Is anyone trying to avoid prosecution or jail for a felony? Yes ☐ No ☒

If yes, Who: _____

(4) Is anyone violating conditions of probation or parole? Yes ☐ No ☒

For the TANF program only - Has anyone been convicted of a violent felony? Yes ☐ No ☐

If yes, Who: _____

For Medicaid and TANF Only - Is anyone in your household pregnant? Yes ☐ No ☐

If yes, name of pregnant woman: _____

Baby's Due Date: _____ Unborn baby's father's name: _____

Father's address: _____

If you have or want Medicaid for the mother, please send in proof of pregnancy with this form.

MEDICAL: For Medicaid Only, does anyone in the household have any unpaid medical bills? Yes ☐ No ☒

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

For Food Stamps Only, does anyone age 60 or older or disabled have medical expenses? Yes ☐ No ☒

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

Yes ☐ No ☐ If yes, list expenses on chart below. Attach bills, prescription drugs for most recent month(s).

Person Who Has The Bill	Type of Expense (Doctor, Hospital, Prescription)	Amount Owed	Date of Bill	Will Insurance Pay? Yes/No

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

If yes, please provide the information below. If you are receiving Medicaid, provide proof:

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

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Does someone else pay any of these medical expenses for you? Yes ☐ No ☐

If yes please provide information below:

Which expense is paid?	Who pays the expense?
To whom does this person pay the bills?	Address:

For Medicaid only, do you have Medicare? Yes ☐ No ☐ Do you have any health insurance **other than** Medicaid? Yes ☐ No ☐ **If yes, send us a copy of your insurance card or insurance information.**

RESOURCES: (Do not complete for children's only Medicaid or Pregnancy Medicaid) Does any person in your household have any of the resources listed below? Yes ☐ No ☐ **(If yes complete the information below. If you are receiving Low Income Medicaid (LIM) or Aged, Blind or Disabled Medicaid provide proof (proof not needed for Medicare Savings Plans - QMB, SLMB or QI-1).**

Resource Type	Owner	Account/Policy # (Do not complete If your account/policy # is the same as your SSN)	Value	Name of Bank, Insurance Company etc.
Cash				
Checking/Savings				
Credit Union				
Annuities				
Stocks or Bonds				
Safe Deposit Box				
Retirement Account				
Vehicles				
CD's				
Pre-Paid Funeral Plans				
Cemetery Plots				
Trust Funds				
Non-Home Place Property				
Home Place Property				
Life Insurance				
Other				

For Aged, Blind or Disabled Medicaid only, have you, your spouse or someone you are applying for sold, traded, or given away a resource in the last 60 months. Yes ☐ No ☐

If yes, when?: _____ What?: _____

EMPLOYMENT: Does anyone in your household work? Yes ☒ No ☐ **If yes, list information about the employed person's pay from employment such as wages, bonus, and tips, and attach proof of ALL gross income received in the last 4 weeks.**

PERSON WORKING	EMPLOYER	PAY PER HOUR	HOURS PER WEEK	HOW OFTEN PAID	DATE(S) PAID	BONUS PAY	TIPS
Sarah Combs	Lane Fast Food	8.60	30	Weekly	Fridays	No	no

Did anyone in your household voluntarily quit a job or voluntarily reduce his/her work hours below 30 hours per week since the last application or last renewal? Yes ☐ No ☒

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If yes, who quit/reduced hours? _____

Date of quit/reduction: _____

What Job was quit/hours reduced? _____

Why did he/she quit/reduce hours? _____

Has anyone stopped working? Yes ☐ No ☒ **If yes, complete the following and provide proof:**

What job stopped?	Name of Household Member who stopped working:	
Place of employment:		
Date Pay Stopped:	Date of Final Check:	Gross amount of final Pay : \$

Has anyone started working? Yes ☐ No ☒ **If yes, complete the following and provide proof:**

Name of person who started working:	Date Started:	Phone Number:
Name of employer/business:	Rate of Pay: \$	Date first check received/will be received:
How often paid (please check one): ☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Other		

SELF-EMPLOYMENT: Is anyone self-employed? Yes ☐ No ☒ *(If yes, who?)* _____

Please provide proof of self-employment income through tax files, business records, receipts, bills, or statements from customers of an established business.

Is this business incorporated? Yes ☐ No ☐

Does this person have any self-employment expenses? Yes ☐ No ☐

If yes, what type of expenses does this person have? _____

For TANF and Medicaid only, provide proof for self-employment expenses.

UNEARNED INCOME: Does anyone in your household receive money from Contributions, Social Security, SSI, VA, Child Support, Unemployment, Retirement or any other income? Yes ☐ No ☒

If yes, complete the information below and provide proof of all income received in the last 4 weeks or the most recent award letter.

Name	Source	Amount	How Often?

DEPENDENT CARE COSTS: Do you pay for the care of a dependent child or of a disabled adult household member? Yes ☐ No ☒ **If yes, complete the questions below; provide proof for TANF and Food Stamps (if monthly amount is over \$200).**

Person who requires care:		Person who pays for care:	
Provider's Name:		How much provider is paid:	How often paid:
Provider's Phone #:	Reason for Care:		

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This section is FOR FOOD STAMPS ONLY - SHELTER COSTS: Did you start paying shelter costs or did your shelter costs change? Yes ☒ No ☐ If yes, complete the chart below.

Expense	Amount	How Often?	Who paid?
Rent/Mortgage	700.00	Month	I did
Property Taxes			
Property Insurance			
Electricity	60.00	Month	I did
Gas			
Fuel oil/Wood/Kerosene			
Well/Septic Tank/Water/Sewage			
Garbage			
Telephone			
Other			

What is the home's primary heating or cooling source? (electricity, gas, air conditioner) electricity

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

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

Have you received energy assistance in the last 12 months? Yes ☐ No ☒

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: _____

For Food Stamps and TANF Only - CHILD SUPPORT: Do you or someone in your household pay child support to someone outside of the home? Yes ☐ No ☒ If yes, complete the chart below:

Who is obligated to pay?	How much is the obligated amount?
For whom is the child support paid?	To whom is the child support paid?

For Food Stamps only, please provide proof of amount paid in the past 3 months and the legal obligation to pay.

This section is FOR TANF RECIPIENTS ONLY – You must complete the following:

Shot Records:

Is there any child under age 7, who is not yet enrolled in school? (Pre-K is **not** considered "school.")

Yes ☐ No ☐ If yes, send Form 3231- Child Care Immunization form for each child under age 7.

School Requirements:

Are all children (6-18 yrs old) attending school? Yes ☐ No ☐

If yes, name(s) of child (ren) _____

Name of school(s) _____

Grade(s) _____

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Is there any child 16 years of age or older who is **not** in school? Yes ☐ No ☐

If yes, name of child/children? _____

Please provide a copy of current check stubs if this child is **employed** or a statement from the provider if engaged in **any other work related activity**.

Civil Rights and American with Disabilities Act requirements:

Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act prohibit discrimination against a person with a disability. If you have a physical or mental condition that makes it harder for you to do the things we require you to do, we may be able to help you. Physical or mental conditions include, for example, diabetes, epilepsy, heart disease, a learning disability, mental retardation, a history of drug or alcohol addiction, depression, impaired mobility, impaired hearing or impaired vision. If you need help, tell us and we will work with you to see what you need. If it is determined that you have a disability that substantially limits one or more major life activities, you may have rights under the ADA and Section 504

If you answer "yes" to the following question, you will not be denied benefits or services because of your disability.

Do you or anyone in your household have any physical or mental condition that makes it harder for you to do the things that we require you to do? Yes ☐ No ☐

(Physical or mental conditions include, but are not limited to, diabetes, epilepsy, heart disease, a learning disability, mental retardation, a history of drug or alcohol addiction, depression, impaired mobility, impaired hearing or impaired vision).

If yes, please let us know the name of the disabled person: _____

Nature of disability: _____

How we can help:

- we can explain the letters that we send to you
- we can amend or revise your plans
- we can help you request a hearing if you ask us
- we can waive certain requirements

Domestic Violence:

Are you or anyone in your household a victim of Domestic Violence? Yes ☐ No ☐

If yes, please let us know the name of domestic violence victim _____

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

Auto Expense: Are you the parent or a relative of the child (or children) and are included in the TANF AU with the child (or children)? Yes ☐ No ☐

If yes, answer the following questions:

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

If yes, who? (Name of owner) _____

Year, Make and Model of the vehicle: _____

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

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

If yes please list: _____

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RIGHTS AND RESPONSIBILITIES

HEARING NOTICE:

In all programs you have the right to request a fair hearing in writing or in person. If you do not agree with the action taken on your case, you may request a fair hearing. You may ask for a hearing by calling your local DFCS office.

Medicaid cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs. To report 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 ARE RESPONSIBLE FOR:

- giving your worker correct information and providing proof of statements needed to receive benefits. When you sign this form, you are giving your worker permission to get information from your employer, bank, neighbor or others so we can make sure you are receiving the correct amount of benefits.
- telling the truth at all times. If you or someone who is applying for you provides incorrect information, you may be committing a crime, and you may go to jail.
- providing proof that you or anyone in your household applying for benefits is a U.S. citizen or qualified immigrant.
- cooperating with state and federal personnel who work for Fraud Prevention or the Office of Investigative Services and who are doing special case reviews. If you do not cooperate and we cannot determine that you are still eligible for Food Stamps, your case may be denied or closed.
- (for Food Stamps) cooperating with Quality Control reviewers when they call or come to your home to interview you about the information you have given your case manager. If you do not cooperate with them, your case may be denied or closed.
- (for Food Stamps and TANF) repaying benefits you should not have received.
- (for Medicaid) cooperating with Medicaid Eligibility Quality Control or Program Integrity when they call or come to your home to interview you about the information you have given your case manager.
- (for Medicaid) members who are 55 years or older and in either a Nursing Home, Intermediate Care Facility, Community-Based Service, or are enrolled in and receive services through a waiver program, cooperating with Estate Recovery.

If you receive **Food Stamps**, you must report when your total gross monthly income goes over the income limit for your household size. You must report this change no later than the 10th day from the end of the month in which the change occurred.

If you receive **TANF or Medicaid**, you must report **all changes** in your situation within 10 days of the change occurring.

I understand that any lump sum or "windfall" payment that any person in my Medicaid case receives must be budgeted, along with any other income that we might have, to determine eligibility.

In the **Medicaid** Program, you have a right to:

- Receive Medicaid even if you have other health insurance
- Choose your Medicaid doctor or provider
 - Peachcare for Kids® and those members who are not aged, blind, or disabled must select from their Care Management Organization (CMO)
 - Members who participate in fee-for-services may select any Medicaid participating provider
- Have your Medicaid application approved or denied within 10, 45, or 60 days from the date you apply, depending on the type of Medicaid

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As a condition of my Medicaid eligibility:

- I agree to assign to the State all rights to medical support and to payment for medical care from any third party (hospital and medical benefits). I agree to cooperate with the State in identifying and providing information to assist the State in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days. (If you are completing this form on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described above as a condition of his/her eligibility for Medicaid).
- I agree to give the State the right to require an absent parent to provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services (DCSS) 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. If you are the victim of domestic violence or have another reason why you think it may not be in the best interest of your child to cooperate with DCSS, you may claim good cause to not cooperate. Contact DFCS if you wish to claim good cause.

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

- Do not give false information or hide information
- Do not use someone else's Food Stamp benefits or EBT card
- Do not trade Food Stamps for illegal items; such as firearms, ammunition or controlled substance (illegal drugs)

Anyone in your household who breaks these rules on purpose can be barred from the Food Stamp program from six months to ten years or permanently.

The person could also be put in prison for up to 20 years, fined up to \$250,000 or both and subject to prosecution under state or federal laws.

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

For Medicaid, 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

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PLEASE SIGN & DATE BELOW IN THE BOX THAT BEST FITS YOUR SITUATION.

IF YOU ARE APPLYING FOR/RENEWING YOUR MEDICAID AND FOOD STAMPS OR TANF, YOU MUST SIGN AND DATE EITHER BOX ① OR BOX ② AND BOX ③.

PLEASE RETURN THIS FORM BY THE 10th OF THE FOLLOWING MONTH OR AT LEAST TWO DAYS PRIOR TO YOUR FOOD STAMPS APPOINTMENT.

① For Medicaid only – sign here when the Applicant/Member/Legal Guardian is completing:

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

(Signature)

(Date)

② For Medicaid only – sign here when a Person Other Than Applicant/Member/Parent/Legal Guardian is completing:

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

(Signature)

(Date)

Phone number where you can be reached _____

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

(Applicant/Member/Parent/Legal Guardian)

(Date)

③ For Food Stamps and/or TANF – when the Applicant/Recipient/Legal Guardian is completing:

I understand that the information I provide on this report may result in a change in my benefits, including a lower amount of benefits or no benefits. I understand that such changes may be made to my benefits without a timely notice. I confirm that all information provided on this form is correct to the best of my knowledge.

Marcus Combs

(Signature)

10/5/xx

Date

For Office use only:

Worker Signature: _____ **Date:** _____