

Georgia Department of Human Resources
**APPLICATION FOR TANF (Temporary Assistance for Needy Families),
FOOD STAMPS OR MEDICAL ASSISTANCE**

We will consider this application without regard to race, color, sex, age, disability, religion, national origin or political belief.

Today's Date: _____

Date Received by DFCS: _____

To apply for benefits, you only have to fill out in Section I the name of the head of household and address where you can be reached, sign your name and give us this application today. Write the telephone number where you can be reached during the day. If you cannot be interviewed today, leave this application with us, because some benefits, such as Food Stamps, are provided from the date you give us this application. We have 30 days from the day you give us the signed Food Stamp application to act on it, and 45 days to act on your application for TANF or Medical Assistance (Medicaid). If you are applying for Medical Assistance as a disabled person, we have up to 60 days to act on your application. If you are applying for Medical Assistance as a pregnant woman, we have up to 10 days to act on your application. **If you cannot understand or complete any portion of this application or cannot adequately communicate with Georgia Department of Human Resources staff due to a disability or difficulty in speaking, writing or understanding English, you or your representative should notify Georgia Department of Human Resources staff and assistance will be provided free of charge.**

| | | |
|--|---|------------------------|
| I. Applicant's Name and Address (NAME) | | |
| 1. First: _____ Middle: _____ Last: _____ Suffix: _____ | | |
| 2. What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ Your Date of Birth: _____ | | |
| 3. Are you visually/hearing impaired and need special assistance with the application process? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check one: <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired | | |
| 4. Do you live in public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Phone Number: () _____ area code | |
| 6. Home Address: | | |
| Street: _____ | Apartment No. _____ | Box or Route No. _____ |
| City: _____ | State: _____ | Zip: _____ |
| 7. Mailing Address: (If same as above write "same as home") | | |
| Street: _____ | Apartment No. _____ | Box or Route No. _____ |
| City: _____ | State: _____ | Zip: _____ |
| 8. Signature of Applicant: _____ | | |
| II. Assistance Desired (KIND) | | |
| Check each type of assistance you are applying for: | | |
| <input type="checkbox"/> TANF (Temporary Assistance for Needy Families) | | |
| <input type="checkbox"/> Refugee Cash Assistance | | |
| <input type="checkbox"/> Food Stamps | | |
| <input type="checkbox"/> Medicaid for families with children and/or pregnant women | | |
| <input type="checkbox"/> Medicaid for the Elderly, Blind or Disabled | | |
| <input type="checkbox"/> Foster Care or Adoption Assistance | | |
| <input type="checkbox"/> Other Assistance (specify) _____ | | |

III. Household Circumstances (CIRC)

IMPORTANT: Your household may be able to get Food Stamps within 5 days of the date we receive your application if your household is in at least one of the following situations:

- You have monthly income of less than \$150.00 and resources (such as cash and money in the bank) of no more than \$100.00
- The members of your household are migrant or seasonal farm workers with no more than \$100.00 in liquid resources and with income for the month of application from one of the following: terminated source, new source or a combination of a terminated and new source.
- The resources and combined monthly income of all members of your household are less than your monthly shelter costs.

Please answer the following questions below so that we can determine if you fit one of these situations.

Note: You need to answer 1-4 only if you are applying for Food Stamps. Answer 5-15 if you are applying for any type of assistance, including Food Stamps.

1. Total amount of income you and your household members have received and /or will receive for working this month: \$
2. Total amount of other income you and your household members have received and /or will receive this month: (Specify, such as Social Security, SSI, Unemployment Compensation, etc.)
\$
3. Total amount you and your household members have in cash or in bank accounts:
Cash: \$ | Bank Account: \$
4. Total amount you and your household members pay for rent, mortgage and utilities each month: \$

IV. Other Household Circumstances (CIRC)

Check any of the following that apply to you or to the person(s) for whom you are applying for assistance. This will help us determine the correct class of assistance for your situation.

5. ☐ Are you applying for Medicaid for a person over the age of 18 whose Supplemental Security Income (SSI) check has been stopped?
6. ☐ Are you applying for Medicaid to cover unpaid medical bills from the past three months or from the three months prior to a SSI application?
7. ☐ If you are applying for Medicaid, are you or your spouse currently covered by Medicare?
8. ☐ Are you applying for Medicaid to help pay for community based waiver services provided under programs such as Community Care Services, Mental Retardation Waiver, Hospice Care, Independent Care Waiver or the Deeming Waiver (Katie Beckett)?
9. ☐ Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
10. ☐ Are you applying for Medicaid to help pay for the care of a person 65 years of age or older or a disabled person who has been in a hospital for at least 30 days or who died in the hospital?
11. ☐ If you are applying for Food Stamps, are you living in a shelter for battered women and children?
12. ☐ If you are applying for Food Stamps, are you a migrant worker or a seasonal farm worker?
13. ☐ Are you a refugee?
14. ☐ If you are an adult applying for Medicaid for your dependent child(ren) who lives with you, do you need Medicaid for yourself because of a specific illness or medical problem you are experiencing?
15. ☐ Do you want to appoint someone to act as your authorized representative in the application process, or to receive notices, or to cash in your Food Stamp benefits for you?

V. Deductions For Food Stamp Program Household Expenses

If your household properly reports and verifies certain household expenses, the expenses may be allowed in determining the amount of benefits you may receive. Failure to report or verify any of these expenses (medical, dependent care, rent, mortgage, taxes, insurance, utility bills, child support payments) which your household may incur and may be allowed in your household's budget will be seen as a statement by your household that you do not want to receive a deduction for the unreported or unverified expense.

VI. Household Members (MEMB)

Beginning with yourself, list all persons living at your address. If you are applying for Medicaid for someone in a nursing home, please list his/her spouse who lives at home, if any.

SOCIAL SECURITY NUMBERS – You will be asked to provide Social Security Numbers (SSNs) for all persons (including yourself) for whom you want assistance. If any of these persons do not have an SSN, we can help you apply for one. Providing or applying for an SSN is voluntary; however, any person who wants assistance but who doesn't want to give information about his or her SSN will not be eligible for benefits. Other family or household members may still get benefits if they are otherwise eligible. If you are applying only for emergency Medicaid because of your immigration status, you do not need to give us information about your SSN.

SSNs are used to verify your family's income and to conduct computer matching with other agencies (such as the Social Security Administration, the Internal Revenue Services, credit reporting agencies) and other matching sources.

VI. Household Members (MEMB) Continued

If you are applying for:

TANF – You are only required to provide the SSN for individuals who are seeking or receiving assistance or whose needs, income and resources are considered in determining the amount of assistance. You are not required to provide the SSN for individuals who are not seeking or receiving assistance or whose needs, income and resources are not considered in determining the amount of assistance. If it is determined that a member of your assistance unit is ineligible for assistance, that individual is not required to provide his or her SSN in order for other individuals in the family to receive TANF benefits.

FS – You are required to provide the SSN for individuals who are members of your household for whom you are applying for assistance. No individuals providing their SSN can be denied Food Stamps just because other household members have not provided their SSNs.

MEDICAID – You are required to provide the SSNs for individuals who are seeking Medicaid benefits, but you are not required to provide the SSN for individuals who are not seeking these benefits.

If you are applying for benefits other than Medicaid, TANF, or Food Stamps, you should ask your caseworker whether you are required to provide your SSN or the SSN of any other person.

| Name (First, Middle, Last, Suffix) | Relationship to Applicant | Date of Birth | Sex | Race | SSN (see above) | Pregnant? Yes/No If yes, give Due date |
|------------------------------------|---------------------------|---------------|-----|------|--------------------|--|
| | SELF | | | | | |
| | SPOUSE | | | | | |
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VII. Additional Social Security Numbers and Name (SSNA)

Have any of the members of your household, for whom a social security number was provided above, used a different name or social security number?

| | | | |
|-------------|-----------------|-------------|----------------------|
| Name: _____ | Alternate _____ | Name: _____ | Alternate SSN: _____ |
| Name: _____ | Alternate _____ | Name: _____ | Alternate SSN: _____ |
| Name: _____ | Alternate _____ | Name: _____ | Alternate SSN: _____ |

VIII. Authorized Representatives (AURP)

1. Do you want to appoint someone to act as your representative in the application process, or to receive notices, or to cash in your Food Stamp benefits for you? Yes ☐ No ☐

2. How would you like for this person to act as your representative, and for which program(s)? (i.e., TANF, Food Stamps)

3. What is this person's relationship to you? _____

4. What is this person's name, address and phone?

Name: _____ Phone () _____

Street: _____

City: _____ State: _____ Zip: _____

Have you recently received benefits in another **COUNTY**? ☐ Yes ☐ No

If Yes, what county and when? _____

Have you recently received benefits in another **STATE**? ☐ Yes ☐ No

If Yes, what state and when? _____

PLEASE ANSWER THESE QUESTIONS FOR TANF AND/OR FOOD STAMPS

1. Is anyone in your household fleeing to avoid prosecution, custody, or confinement after conviction, under the law?

☐ Yes ☐ No If Yes, who? _____

2. Is anyone in your household in violation of his/her parole/probation?

☐ Yes ☐ No If Yes, who? _____

3. Has anyone in your household fraudulently misrepresented his/her identity or residence to receive any benefits?

☐ Yes ☐ No If Yes, who? _____

4. Has anyone in your household been found guilty of a felony related to a controlled substance (drugs)?

☐ Yes ☐ No If Yes, who? _____

PLEASE ANSWER THESE QUESTIONS IF YOU ARE APPLYING FOR TANF:

1. Has anyone in your household been found guilty of a serious violent felony?

☐ Yes ☐ No If Yes, who? _____ What type of felony? _____

PLEASE ANSWER THESE QUESTION IF YOU ARE APPLYING FOR FOOD STAMPS:

1. Has anyone in your household been found guilty by a court of selling food stamps of \$500 or more?

☐ Yes ☐ No If Yes, who? _____

2. Has anyone in your household been found guilty of using food stamps to buy firearms, ammunition or explosives?

☐ Yes ☐ No If Yes, who? _____

3. Has anyone in your household been found guilty of using food stamps to buy illegal drugs?

☐ Yes ☐ No If Yes, who? _____

4. Do you understand that some able bodied food stamp recipients (without dependent children) will only be eligible to receive food stamps for a 3 month period; unless working or participating in certain education, training or work experience programs for at least 20 hours per week? ☐ Yes ☐ No If Yes, who? _____

I have read the parts of this form that apply to me and my household. All the information which I have provided is true and complete as far as I know. The answers I have given in my interview are true. I understand I must report changes to my case manager within 10 days of the occurrence.

Signature

Date

Authorized Representative

Date

Case Manager

Date