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

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept.

Check block(s) that apply to you:

- ❑ Pregnant Woman
- ❑ Women's Health
- ❑ Child under 19
- ❑ Parent Caretaker
- ❑ Katie Beckett
- ❑ Chafee Independence Program Medicaid
- ❑ Planning for Health Babies (P4HB)

Were you in foster care on your 18th birthday? ❑ Yes ❑ No, in which state?_____

PLEASE NOTE: A face-to-face interview is not required for Medicaid applications. Please answer all questions as completely and accurately as possible. **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).**

Your Name: (Please Print) FIRST M.I. Last Maiden (if applicable)		Today's Date:	
Mailing Address:	City:	State:	Zip Code:
Residence Address (if different from Mailing Address):	Phone Number(s):	E-mail Address:	
Electronic Communication: Yes___ or No___ (optional)*	What is your Preferred Language? If an interview is required, will you need an interpreter? Yes__ No__		

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?

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE

You can give a trusted person or organization permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf.

This person or organization is called an "authorized representative." If you ever need to change your authorized representative, contact Division of Family and Children Services (DFCS) at (877) 423-4746. If you are a legally appointed representative for someone on this application, submit proof with the application.

Person Name: (Please Print) FIRST Last		Organization Name (if applicable):	
Address:	City:	State:	Zip Code:
What is your Preferred Language? If an interview is required, will you need an interpreter? Yes ___ No ___	Phone Number(s):	Electronic Communication: Yes___ or No___ (optional)* E-mail address:	

Authorized Representative 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 ❑

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance <u>for Authorized Representatives</u> (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?

*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.

Please list all persons living with you for whom you want or DON'T want Medicaid, including yourself. You do not have to provide an SSN or immigration status information for any person who is not asking for Medicaid. If provided, we will use the SSN for computer matches with other agencies and it may help us process your child's application. We will NOT share your information with the Department of Homeland Security (formerly the INS).

First Name	MI	Last Name	Suffix (Jr.)	Race	Sex M/F	Date of Birth	Relationship to You	Does this person need health coverage? (Y/N)	Social Security Number	Is this person a U.S. Citizen, U.S. National or qualified alien/immigrant? (Y/N)	Does the Father of this child live in your home? (Y/N)	Does the Mother of this child live in your home? (Y/N)

If you or other household members are a Naturalized Citizen, or a qualified alien/immigrant complete the following chart.

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

Are you pregnant? ❑Yes ☐ No; If yes what is the estimated due date? _____; and how many babies are expected? ____; If no, did you deliver or was a pregnancy terminated the last 12 months? ❑Yes ☐ No; If yes, what was the delivery/termination date? _____; and how many babies were delivered/expected? ____; Are you able to have a baby? ❑Yes ☐ No; Have you ever delivered a baby weighing less than 2500 grams (5 pounds, 8 ounces)? ❑Yes ☐ No; Have you delivered a baby weighing less than 1500 grams (3 pounds, 5 ounces) on or after January 1, 2011? ❑Yes ☐ No; Do you have any unpaid medical bills from the past three months? ❑Yes ☐ No; If yes, which months? _____; Are you currently covered by other Health Insurance? ❑Yes ❑No; Are you currently on Medicaid? ❑Yes ☐ No; If yes, list Insurance Company and policy number: _____; Does anyone in the household have any private health insurance? ❑Yes ☐ No
Have you or anyone in your household been diagnosed with Breast or Cervical Cancer? ❑Yes ❑No If yes, have you received Women's Health Medicaid previously? ❑Yes ❑No

INCOME/SELF-EMPLOYMENT, TAX FILER INFORMATION, DEDUCTIONS and DEPENDENT CARE

List all income received by persons on page 1 of this application. Be sure to show the amount before deductions. Attach an extra sheet if necessary. We will decide, based on the type of Medicaid, whose income must be counted and whose may be excluded.

Income	Gross Amount per Paycheck (amount before deductions)	How Often? (weekly, every 2-weeks, monthly, etc.?)	Name of Person Receiving
Wages/Earnings			
Current Employer:			
Wages/Earnings			
Current Employer:			
Social Security Income/SSI			
Worker's Compensation			
Pensions or Retirement Benefits			
Child Support/ Contributions			
Unemployment Benefits			
Other Income, please specify:			

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 filers claim any dependents on their tax return? ❑Yes ❑No
   If **YES**, please list the names of the dependents: _____
   _____
4. Will anyone be claimed as a tax dependent on someone else's return? ❑Yes ❑No
   If **YES**, please list the name of the tax filer and the tax dependents:
   _____
   _____

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

If you or anyone on page 1 on this application is self-employed, complete the chart below.

Type of self-employment	Name of person self-employed	Monthly gross amount	Monthly business expenses amount

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

❑ Alimony paid Amount: _____ How often? _____ ❑ Student loan interest Amount: _____ How often? _____

❑ Health Insurance Premiums, 401K, and Other Pre-Tax Deductions $_____ How often? _____

❑ Other deductions Type: _____ Amount: _____ How often? _____

Do you pay for dependent care (daycare for a child or care for an adult who cannot care for himself/herself) so that someone in your household can work?

Name of Parent who works	Name of child or adult cared for	Name of care provider	Amount of Payment	How Often? (weekly, 2-weeks, monthly, etc.)

If you are applying for Medicaid for children and one or both of their parents are not in the home, please provide the following information:

Child's Name	Absent Parent's Name (Mother/Father)	Do they have Medical Coverage on the Child?	If Yes to Medical Coverage, please list name of insurance company & group number

EXPRESS LANE ELIGIBILITY:

Express Lane Eligibility (ELE) is an automatic process to enroll or renew eligible children under the age of 19 who are receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) into the Medical Assistance program.
If you are receiving SNAP or TANF, the Division of Family and Children Services (DFCS) will use the household size, residency, and income information from SNAP or TANF, but DFCS will verify citizenship or immigration status using Medical Assistance rules to make an ELE determination to enroll or renew the children in Medicaid or PeachCare for Kids®. If your children are eligible for PeachCare for Kids®, they may be subject to a premium. DFCS will send you a determination notice, let you make any changes and allow you to opt out at any time.

If you would like your children to be evaluated for Medical Assistance using the ELE process, please select yes or no below.
☐Yes ☐No

I understand that this information may need to be verified to determine eligibility. I understand wage and salary information supplied by the Georgia Department of Labor may be obtained to verify and determine eligibility for Medicaid. I agree to assign to the state all rights to medical support and third-party support payments (hospital and medical benefits). I agree to give the State the right to require an absent parent 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. I understand that I must report changes in my income and circumstances within ten (10) days of becoming aware of the change.

The Georgia Department of Human Services ("DHS") collects Personally Identifiable Information (PII), such as names, addresses, telephone numbers, email addresses, and dates of birth, etc., during your application for benefits. By submitting any personal information to us, you agree that we may collect, use, and disclose any such personal information in accordance with DHS policies, procedures, and as permitted or required by law and/or regulations.

- ❑ I declare under penalty of perjury that I am a U.S. Citizen, U.S. National or qualified alien in the United States. If I am a parent or legal guardian, I declare that the applicant(s) is a U.S. Citizen, U.S. National or qualified alien in the United States.
- ❑ I declare to the best of my knowledge and belief that the person(s) for whom I am applying for Medicaid is/are U.S. citizen(s), U.S. National(s) or qualified alien in the United States. I further certify under penalty of perjury that all of the information provided on this application is true and correct to the best of my knowledge.

Applicant Signature:_____ Date: _____

Authorized Representative 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.

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 (877) 423-4746 or the DCH Katie Beckett (KB) Team at (678) 248-7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dfcs.georgia.gov/adasection-504-and-civil-rights, or you may obtain the DCH ADA Reasonable Modification Request Form from the KB Team 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, 29th Floor, Atlanta, GA 30303, (877) 423-4746. 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. The DCH email is: dch.adarequests@dch.ga.gov.

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. The email for DCH Civil Rights complaints is: dch.civilrights@dch.ga.gov. The link for the DCH Civil Rights process and complaint form is located at https://dch.georgia.gov/adasection-504-and-civil-rights.

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

Under DHS, you may file discrimination complaints by contacting your local DFCS office or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746 (voice).

ATTACHMENT A

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____ - _____ - _____

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) _____ - _____
5. Employer address	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( ) –	12. Email address

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

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

EMPLOYER COVERAGE TOOL

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Use this tool to help answer questions in Attachment A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Attachment A. For example, the answer to question 14 on this page should match question 14 on Attachment A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number _____ - _____ - _____

EMPLOYER Information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN) _____ - _____	
5. Employer address	6. Employer phone number ( ) –	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

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ATTACHMENT B

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

American Indian or Alaska Native Family Member (AI/AN)

Complete this attachment if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often?_____	$ _____ How often?_____

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ATTACHMENT C

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person or organization permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person or organization is called an "authorized representative." If you ever need to change your authorized representative, contact Division of Family and Children Services (DFCS) at 1-877-423-4746. If you're a legally appointed representative for someone on this application, submit proof with the application. If you need to assign more than one authorized representative, please complete another Attachment C.

1. Person Name (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number
( ) –

8. Organization name

9. ID number (if applicable)

10. Authorized Representative 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 ❑

11. Preferred Language

12. Is an interpreter needed? Yes ❑ No ❑

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

13. Your signature

14. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

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

3. Organization name

4. ID number (if applicable)

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GEORGIA PATHWAYS TO COVERAGE™

ATTACHMENT D

GEORGIA DEPARTMENT OF HUMAN SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Person Name 1: _____ Person DOB 1: _____

Pathways Program

Pathways Medical Assistance is a program that provides free or reduced cost Medicaid coverage to individuals ages 19 to 64 who have household income up to 100% of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid coverage and who meet the eligibility criteria and requirements. As a condition of eligibility, individuals must be currently engaged at the time of application in at least 80 hours of a qualifying activity or combination of activities per month. Individuals or members with disabilities may request Reasonable Modifications for Pathways in order to meet the qualifying activities requirement. This program is part of our goal to advance the health, wellness and independence of those we serve. Many activities count towards your program eligibility. You may already be doing an activity that makes you eligible to the program. And there are benefits to joining the program in addition to getting your medical assistance coverage. These additional benefits include: 1) supports that can assist you while participating if needed and 2) access to a future Rewards Account in which you can earn dollars by completing certain healthy activities.

Please read the Pathways contract below and indicate if you understand and acknowledge the terms and would like to be considered for Pathways. If you would like to be considered for Pathways, you must sign the contract. Each person must sign a separate contract.

Pathways Contract

I understand that if I am determined eligible for Pathways, I must meet the following requirements to maintain ongoing Medical Assistance coverage through Pathways. In Pathways, I would be required to complete the following for the duration of my coverage:

- Complete a minimum of 80 hours of work, work-related, higher education, or community service activities each month
- Report my work, work-related, higher education, or community service activity hours and provide verification each month. If I report and provide verification of my hours for six consecutive months, I will only be required to report changes to my activity status
- Comply with random and periodic audits to verify my ongoing compliance
- Make a monthly premium payment (equal to $7-16 dollars per month if my monthly income is at or above 50% of the Federal Poverty Level)
- Report if I have access to health insurance through my employer or a family members' employer
- Enroll in employer sponsored health insurance (ESI) with cost-sharing support through Medicaid if I have access to coverage that is determined cost-effective for the State. Cost-effectiveness means that it costs the state less for you to enroll in your ESI than for you to enroll in Medicaid.
- Access a Rewards Account in which I can earn dollars by completing certain health behaviors activities and copayments for provider visits will be automatically deducted

I want to be considered for Pathways if I am not eligible for another class of medical assistance. Pathways is medical assistance for individuals earning up 100% Federal Poverty Level, who are not otherwise eligible for Medicaid, and who are engaged in 80 hours of work, work-related, higher education, or community service activities each month. I understand that if I fail to meet any of the requirements above, I will be terminated from the program and will lose access to medical assistance coverage. ☐ Yes ☐ No

ESI cost-effectiveness is made by a third-party vendor. This process is only mandatory if you have access to ESI. If you have ESI access, the vendor will receive your personal information (such as your SSN, DOB, and address) and use it to verify your ESI. If you are not the policyholder, the vendor will also receive personal information of the policyholder. Do you consent to your personal information being sent to a third-party vendor to determine cost-effectiveness, understanding that the vendor may reach out to the employer for verification? Your consent indicates that you have the consent of the policyholder. Without consent, you will not be eligible for Pathways. If you are the ESI policyholder, your response may also impact Pathways eligibility for a spouse/family member on the application**.** ☐ Yes ☐ No

Are you the person to whom this contract applies? ☐ Yes ☐ No

Is the applicant available to sign? ☐ Yes ☐ No

Are you the authorized representative signing on behalf of this person? ☐ Yes ☐ No
If you are the authorized representative, you should sign on the authorized representative signature line only and provide information required on Attachment C.

GEORGIA PATHWAYS TO COVERAGE™

ATTACHMENT D

GEORGIA DEPARTMENT OF HUMAN SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

If you are a student and would like to use your enrollment in an institution of higher education as your Qualifying Activity, do you consent to release your education records to GA Gateway for the purpose of validating your Qualifying Activity engagement in the Pathways Medical Assistance Program? If available, your consent will release your school's name, each term start and end date, and the credit hours for which you are enrolled. ☐ Yes ☐ No

☐ I have read, understand, and acknowledge the terms of the Pathways Contract and have actively chosen to participate in the Pathways Program based upon my responses above.

_____ _____

Applicant Signature Date

_____ _____

Authorized Representative Signature Date

GEORGIA PATHWAYS TO COVERAGE™

ATTACHMENT D

GEORGIA DEPARTMENT OF HUMAN SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Person Name 1: _____ Person DOB 1: _____

Please complete each section below if you signed the Pathways contract and would like to be considered for Pathways.

Qualifying Activities and Hours Information

Check the qualifying activity (QA) or combination of activities in which you currently participate. You will need to provide supporting documentation of your activity for the most recent four weeks available within the eight weeks prior to the application date. You can also provide supporting documentation if you have worked a minimum of 80 hours per month for six consecutive months prior to the application date.

1. **Qualifying Activity** (check all that apply):

☐Employment (public or private sector)
☐On-the-Job Training
☐Community Service
☐Institution of Higher Education (IHE)
☐Self-employment
☐Job Readiness Assistance
☐Vocational Educational Training (Voc. Training)
☐Georgia Vocational Rehabilitation Agency (GVRA)

2. **Qualifying Activity Start Date, End Date and Hours** (list each qualifying activity checked above with name of employer/organization, school/institution, start date, end date (if applicable) and hours):

Type of Qualifying Activity	Name of Employer/Organization	Start Date	End Date	Hours per month
Type of Qualifying Activity (Education)	**Name of School/Institution**	**Enrollment Term Start Date**	**Enrollment Term End Date**	**Credit Hours**

3. Are you currently enrolled in the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant program? ☐ Yes ☐ No

4. Due to a disability, are you unable to meet the qualifying hours and activities for Pathways and request assistance for additional time to meet reporting requirements at application; and/or additional time for a referral to Georgia Vocational Rehabilitation Agency (GVRA) as a Reasonable Modification? ☐ Yes ☐ No

5. For GVRA participants only, do you consent to release your personal information to the Georgia Vocational Rehabilitation Agency (GVRA) for the purpose of validating your enrollment in GVRA and your Qualifying Activity engagement in the Pathways Medical Assistance Program? ☐ Yes ☐ No

Tobacco Use Information

6. Do you currently use tobacco products or Electronic Nicotine Delivery System devices? ☐ Yes ☐ No
This information applies to persons who use tobacco products or Electronic Nicotine Delivery System devices. Examples of tobacco products include but are not limited to cigarettes, cigars, pipes, chewing tobacco, smokeless tobacco. Examples of Electronic Nicotine Delivery System devices include but are not limited to vaper and electronic cigarettes.

GEORGIA PATHWAYS TO COVERAGE™

ATTACHMENT D

GEORGIA DEPARTMENT OF HUMAN SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Person Name 2: _____ Person DOB 2: _____

Pathways Program

Pathways Medical Assistance is a program that provides free or reduced cost Medicaid coverage to individuals ages 19 to 64 who have household income up to 100% of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid coverage and who meet the eligibility criteria and requirements. As a condition of eligibility, individuals must be currently engaged at the time of application in at least 80 hours of a qualifying activity or combination of activities per month. Individuals or members with disabilities may request Reasonable Modifications for Pathways in order to meet the qualifying activities requirement. This program is part of our goal to advance the health, wellness and independence of those we serve. Many activities count towards your program eligibility. You may already be doing an activity that makes you eligible to the program. And there are benefits to joining the program in addition to getting your medical assistance coverage. These additional benefits include: 1) supports that can assist you while participating if needed and 2) access to a future Rewards Account in which you can earn dollars by completing certain healthy activities.

Please read the Pathways contract below and indicate if you understand and acknowledge the terms and would like to be considered for Pathways. If you would like to be considered for Pathways, you must sign the contract. Each person must sign a separate contract.

Pathways Contract

I understand that if I am determined eligible for Pathways, I must meet the following requirements to maintain ongoing Medical Assistance coverage through Pathways. In Pathways, I would be required to complete the following for the duration of my coverage:

- Complete a minimum of 80 hours of work, work-related, higher education, or community service activities each month
- Report my work, work-related, higher education, or community service activity hours and provide verification each month. If I report and provide verification of my hours for six consecutive months, I will only be required to report changes to my activity status
- Comply with random and periodic audits to verify my ongoing compliance
- Make a monthly premium payment (equal to $7-16 dollars per month if my monthly income is at or above 50% of the Federal Poverty Level)
- Report if I have access to health insurance through my employer or a family members' employer
- Enroll in employer sponsored health insurance (ESI) with cost-sharing support through Medicaid if I have access to coverage that is determined cost-effective for the State. Cost-effectiveness means that it costs the state less for you to enroll in your ESI than for you to enroll in Medicaid.
- Access a Rewards Account in which I can earn dollars by completing certain health behaviors activities and copayments for provider visits will be automatically deducted

I want to be considered for Pathways if I am not eligible for another class of medical assistance. Pathways is medical assistance for individuals earning up 100% Federal Poverty Level, who are not otherwise eligible for Medicaid, and who are engaged in 80 hours of work, work-related, higher education, or community service activities each month. I understand that if I fail to meet any of the requirements above, I will be terminated from the program and will lose access to medical assistance coverage. ☐ Yes ☐ No

ESI cost-effectiveness is made by a third-party vendor. This process is only mandatory if you have access to ESI. If you have ESI access, the vendor will receive your personal information (such as your SSN, DOB, and address) and use it to verify your ESI. If you are not the policyholder, the vendor will also receive personal information of the policyholder. Do you consent to your personal information being sent to a third-party vendor to determine cost-effectiveness, understanding that the vendor may reach out to the employer for verification? Your consent indicates that you have the consent of the policyholder. Without consent, you will not be eligible for Pathways. If you are the ESI policyholder, your response may also impact Pathways eligibility for a spouse/family member on the application**.** ☐ Yes ☐ No

Are you the person to whom this contract applies? ☐ Yes ☐ No

Is the applicant available to sign? ☐ Yes ☐ No

Are you the authorized representative signing on behalf of this person? ☐ Yes ☐ No
If you are the authorized representative, you should sign on the authorized representative signature line only and provide information required on Attachment C.

GEORGIA PATHWAYS TO COVERAGE™

ATTACHMENT D

GEORGIA DEPARTMENT OF HUMAN SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

If you are a student and would like to use your enrollment in an institution of higher education as your Qualifying Activity, do you consent to release your education records to GA Gateway for the purpose of validating your Qualifying Activity engagement in the Pathways Medical Assistance Program? If available, your consent will release your school's name, each term start and end date, and the credit hours for which you are enrolled. ☐ Yes ☐ No

☐ I have read, understand, and acknowledge the terms of the Pathways Contract and have actively chosen to participate in the Pathways Program based upon my responses above.

_____ _____

Applicant Signature Date

_____ _____

Authorized Representative Signature Date

GEORGIA PATHWAYS TO COVERAGE™

ATTACHMENT D

GEORGIA DEPARTMENT OF HUMAN SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Person Name 2: _____ Person 2 DOB: _____

Please complete each section below if you signed the Pathways contract and would like to be considered for Pathways.

Qualifying Activities and Hours Information

Check the qualifying activity (QA) or combination of activities in which you currently participate. You will need to provide supporting documentation of your activity for the most recent four weeks available within the eight weeks prior to the application date. You can also provide supporting documentation if you have worked a minimum of 80 hours per month for six consecutive months prior to the application date.

1. **Qualifying Activity** (check all that apply):

☐Employment (public or private sector)
☐On-the-Job Training
☐Community Service
☐Institution of Higher Education (IHE)
☐Self-employment
☐Job Readiness Assistance
☐Vocational Educational Training (Voc. Training)
☐Georgia Vocational Rehabilitation Agency (GVRA)

2. **Qualifying Activity Start Date, End Date and Hours** (list each qualifying activity checked above with name of employer/organization, school/institution, start date, end date (if applicable) and hours):

Type of Qualifying Activity	Name of Employer/Organization	Start Date	End Date	Hours per month
Type of Qualifying Activity (Education)	**Name of School/Institution**	**Enrollment Term Start Date**	**Enrollment Term End Date**	**Credit Hours**

3. Are you currently enrolled in the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant program? ☐ Yes ☐ No

4. Due to a disability, are you unable to meet the qualifying hours and activities for Pathways and request assistance for additional time to meet reporting requirements at application; and/or additional time for a referral to Georgia Vocational Rehabilitation Agency (GVRA) as a Reasonable Modification? ☐ Yes ☐ No

5. For GVRA participants only, do you consent to release your personal information to the Georgia Vocational Rehabilitation Agency (GVRA) for the purpose of validating your enrollment in GVRA and your Qualifying Activity engagement in the Pathways Medical Assistance Program? ☐ Yes ☐ No

Tobacco Use Information

6. Do you currently use tobacco products or Electronic Nicotine Delivery System devices? ☐ Yes ☐ No
This information applies to persons who use tobacco products or Electronic Nicotine Delivery System devices. Examples of tobacco products include but are not limited to cigarettes, cigars, pipes, chewing tobacco, smokeless tobacco. Examples of Electronic Nicotine Delivery System devices include but are not limited to vaper and electronic cigarettes.

GEORGIA PATHWAYS TO COVERAGE™

ATTACHMENT D

GEORGIA DEPARTMENT OF HUMAN SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

The table below lists the acceptable types of Qualifying Activities, description, and verification document.

Qualifying Activity and Description	Verification
Employment • Includes full and part-time work	• Pay stubs • Written statement from source/employer • Gross earnings (if hourly pay is known) • Timesheet
Self-employment • Some examples include but are not limited to owning one's own business, cutting grass, collecting cans for recycling, babysitting, selling food items, taxi/food delivery service, etc.	• Signed Standardized Work/Participation Calendar from member indicating hours engaged (Member may fill in a standardized worksheet template indicating total weekly hours worked per client/activity; OR submit a snapshot of their actual work calendar from the reporting month (e.g. Photo of ledger of appointments or screenshot of calendar with work activities)
On-the-job Training • Training given to a paid employee while he/she is working in the job.	• Statement from supervisor sponsoring the OJT
Job Readiness • Activities directly related to preparation for employment. Some examples include but are not limited to life-skills training, GED course enrollment, resume building, and habilitation or rehabilitation activities, including substance use disorder treatment. Rehabilitation activities must be determined to be necessary and documented by a qualified medical professional. • An inpatient hospital stay is considered a habilitation or rehabilitation activity under job readiness only at initial application. For each day of an inpatient hospital stay, an applicant may claim 4 hours towards their monthly Qualifying Activities requirement.	• Signed statement from Recognized Agency or Community Resource indicating hours engaged. (Recognized agencies include Georgia Department of Labor Career Center, Workforce Development Board, Georgia Vocational Rehabilitation Agency, Goodwill, and other agencies as authorized by the State) • Signed statement from habilitation/rehabilitation institution verifying hours in last four weeks
Community Service • Approved community service programs are limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and childcare.	• Signed Standardized Work/Participation Calendar • Signed statement on organization letterhead from supervisor verifying hours
Vocational Educational Training • Organized educational programs that prepare individuals for employment in current or emerging occupations. Course hour requirements for vocational educational training shall be determined by the Department of Community Health (DCH).	• Official course enrollment for the current semester from the Office of the Registrar • Copy of class schedule for the current semester
Enrollment in an Institution of Higher Education • The student's workload may include any combination of courses, work, research, or special studies that the institution considers contributing to the individual's full-time status.	• Official course enrollment for the current semester from the Office of the Registrar • Copy of class schedule for the current semester
Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation Program	• Signed statement from GVRA, dated within four weeks of submission by the applicant • Enrolment letter dated within four weeks of submission by the applicant