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

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept

Check block(s) that apply to you:

- ❑ Pregnant Woman
- ❑ Families w/Children – LIM
- ❑ Child(ren) Only – RSM
- ❑ Chafee Independence Program Medicaid

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 cannot understand or complete this application, please notify DFCS staff and assistance will be provided free of charge.

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:	

Please list all persons living with you for whom you want Medicaid. List yourself if you want Medicaid for yourself.

First Name	MI	Last Name	Suffix (Jr.)	Race	Sex M/F	Date of Birth	Relationship to You	Social Security Number	Is this Person a U.S. Citizen? (Y/N) (you may qualify for Medicaid even if you answer No)		Does the Father of this child live in your home? (Y/N)		Does the Mother of this child live in your home? (Y/N)	

Please list all persons living with you for whom you DON'T want Medicaid. List yourself if you don't want Medicaid. You do not have to provide a 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).

Is anyone in the household pregnant? ❑ Yes ❑ No If yes, who is pregnant? _____ Due Date: _____ Please attach verification of pregnancy if available.

Do you have any unpaid medical bills from the past three months? ❑ Yes ❑ No If yes, which months? _____

Does anyone in your household have Health Insurance? ❑ Yes ❑ No If yes, list Insurance Company and policy number:

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, RESOURCES and DAYCARE

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. **If you are applying for Children Only or Pregnant Woman Medicaid, you do not have to complete the Resources/Vehicles sections below.**

Income	Gross Amount per Pay Check (amount before deductions)	How Often? (weekly, every 2-weeks, monthly, etc.?)	Name of Person Receiving		Resources	Amount in Account/Value	Who Owns Resource?
Wages/Earnings					**Cash**		
Current Employer:					**Checking Account**		
Wages/Earnings					**Savings Account**		
Current Employer:					**Credit Union**		
Social Security Income/SSI					**401K/Retirement Account**		
Worker's Compensation					**Other**		
Pensions or Retirement Benefits					**Vehicle(s):** Cars, trucks, motorcycles (licensed)		
Child Support/ Contributions					**Make**	**Model**	**Year** / **Amount Owed?**
Unemployment Benefits							
Other Income, please specify:							

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? Yes/No	If Yes to Medical Coverage, please list name of insurance company & group number

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.

❑ I certify under penalty of perjury that I am a U.S. Citizen and/or lawfully present in the United States. If I am a parent or legal guardian, I certify that the applicant(s) is a U.S. Citizen and/or lawfully present in the United States. ❑ I certify 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) 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 (Required): _____ Date: _____