



Application Information-	T21509941
Submission Date and Time	2020-01-30 15:48:03.0

Applying on Your Behalf	
Contact Information	
Applying	
Agency	
Name	
Address	
Address Line1	
Address Line2	
City	
State	
Zip Code	
Phone Number	
Applicant's Relationship to you	

Program Information	
Programs	Medical Assistance

Basic Information	
Applicant Details	
First Name	CHESTER
Middle Initial	
Last Name	SEALE
Suffix	Jr
Gender	Male
Date of Birth	10/23/1948
Primary Language	English
Do you live in Georgia?	Yes
County	Gwinnett
Marital Status	Never Married
Physical Address	
Address Line1	4200 Hopkins Bluff Way
Address Line2	
City	Duluth
State	Georgia
Zip Code	30096
What is your living arrangement?	In This Home
If not living at home, what date did current living arrangement start?	
State lived in before moving in to current living arrangement	

<b>Mailing Address</b>	
Address Line1	4200 Hopkins Bluff Way
Address Line2	
City	Duluth
State	Georgia
Zip Code	30096
<b>Previous Address</b>	
Has the household lived at any other address in the past year?	
<b>Contact Information</b>	
Home Phone	(404) 456-6044
Work Phone	
Extension	
Other Phone	
Email Address	
What is the best way to getting in touch during the weekday?	
What is the best time to call during the weekday?	
When did this information change?	

<b>People In Your Home- CHESTER SEALE</b>	
<b>Personal Information</b>	
First Name	CHESTER
Middle Initial	
Last Name	SEALE
Suffix	Jr
Gender	Male
Date of Birth	10/23/1948
What is the primary language of household?	English
Other Language	
If an interview is needed do you need an interpreter?	
Do you need assistance while communicating with us	
Other type of help communicating	
What is this person's Marital Status?	Never Married
What is this person's Living Arrangement?	In This Home
If person is living out of home, what is the reason?	
Does this person intend to file taxes?	No
Is this person claimed as a dependent by someone living outside of the home?	No
<b>Program Selection</b>	
Programs	Medical Assistance
<b>Alternative Name Information</b>	
Is this person known by any other name?	
First Name	
Middle Initial	
Last Name	
Suffix	

<b>Social Security Number (SSN) Information</b>	
Social Security Number	422-68-9298
If this person doesn't have a Social Security number (SSN), but has applied for one, when did he or she apply?	12/31/9999
<b>Ethnicity</b>	
Ethnicity	Not Hispanic or Latino
<b>Race</b>	
Race	White
If this person is American Indian/Alaskan Native, are they a member of Federally recognized tribe	
If yes, tribe name	
<b>Personal Information Continued</b>	
Does this person live in Georgia?	Yes
Is this person Blind or disabled?	
Is this person United States Citizen?	Yes
<b>Immigration Information</b>	
What is person's Immigration status?	
When did this person come to US to live?	
What is this person's Immigration document type?	
What is this person's Alien registration number?	
<b>Military Information</b>	
Are you a veteran or active duty member?	No
Is your spouse a veteran or active duty member?	No
If you are applying on behalf of a child, is the parent of the child in the home a veteran or an active duty member?	No
When did this information change?	

<b>People In Your Home- PAULA ROSAS-JAIME</b>	
<b>Personal Information</b>	
First Name	PAULA
Middle Initial	N
Last Name	ROSAS-JAIME
Suffix	--
Gender	Female
Date of Birth	11/30/1980
What is the primary language of household?	English
Other Language	
If an interview is needed do you need an interpreter?	
Do you need assistance while communicating with us	
Other type of help communicating	
What is this person's Marital Status?	Married
What is this person's Living Arrangement?	In This Home
If person is living out of home, what is the reason?	
Does this person intend to file taxes?	No

Is this person claimed as a dependent by someone living outside of the home?	No
<b>Program Selection</b>	
Programs	Medical Assistance
<b>Alternative Name Information</b>	
Is this person known by any other name?	
First Name	
Middle Initial	
Last Name	
Suffix	
<b>Social Security Number (SSN) Information</b>	
Social Security Number	0
If this person doesn't have a Social Security number (SSN), but has applied for one, when did he or she apply?	12/31/9999
<b>Ethnicity</b>	
Ethnicity	Other
<b>Race</b>	
Race	White
If this person is American Indian/Alaskan Native, are they a member of Federally recognized tribe	
If yes, tribe name	
<b>Personal Information Continued</b>	
Does this person live in Georgia?	Yes
Is this person Blind or disabled?	
Is this person United States Citizen?	
<b>Immigration Information</b>	
What is person's Immigration status?	Undocumented Aliens
When did this person come to US to live?	
What is this person's Immigration document type?	
What is this person's Alien registration number?	
<b>Military Information</b>	
Are you a veteran or active duty member?	No
Is your spouse a veteran or active duty member?	No
If you are applying on behalf of a child, is the parent of the child in the home a veteran or an active duty member?	No
When did this information change?	

<b>People In Your Home- BRIANA CALDERON</b>	
<b>Personal Information</b>	
First Name	BRIANA
Middle Initial	P
Last Name	CALDERON
Suffix	--
Gender	Female
Date of Birth	06/25/2005

What is the primary language of household?	English
Other Language	
If an interview is needed do you need an interpreter?	
Do you need assistance while communicating with us	
Other type of help communicating	
What is this person's Marital Status?	Never Married
What is this person's Living Arrangement?	In This Home
If person is living out of home, what is the reason?	
Does this person intend to file taxes?	No
Is this person claimed as a dependent by someone living outside of the home?	No
<b>Program Selection</b>	
Programs	Medical Assistance
<b>Alternative Name Information</b>	
Is this person known by any other name?	
First Name	
Middle Initial	
Last Name	
Suffix	
<b>Social Security Number (SSN) Information</b>	
Social Security Number	673-26-3979
If this person doesn't have a Social Security number (SSN), but has applied for one, when did he or she apply?	12/31/9999
<b>Ethnicity</b>	
Ethnicity	Other
<b>Race</b>	
Race	White
If this person is American Indian/Alaskan Native, are they a member of Federally recognized tribe	
If yes, tribe name	
<b>Personal Information Continued</b>	
Does this person live in Georgia?	Yes
Is this person Blind or disabled?	
Is this person United States Citizen?	Yes
<b>Immigration Information</b>	
What is person's Immigration status?	
When did this person come to US to live?	
What is this person's Immigration document type?	
What is this person's Alien registration number?	
<b>Military Information</b>	
Are you a veteran or active duty member?	No
Is your spouse a veteran or active duty member?	No
If you are applying on behalf of a child, is the parent of the child in the home a veteran or an active duty member?	No

When did this information change?	
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<b>People In Your Home- BRIGGS ROSAS</b>	
<b>Personal Information</b>	
First Name	BRIGGS
Middle Initial	A
Last Name	ROSAS
Suffix	--
Gender	Male
Date of Birth	11/19/2006
What is the primary language of household?	English
Other Language	
If an interview is needed do you need an interpreter?	
Do you need assistance while communicating with us	
Other type of help communicating	
What is this person's Marital Status?	Never Married
What is this person's Living Arrangement?	In This Home
If person is living out of home, what is the reason?	
Does this person intend to file taxes?	No
Is this person claimed as a dependent by someone living outside of the home?	No
<b>Program Selection</b>	
Programs	Medical Assistance
<b>Alternative Name Information</b>	
Is this person known by any other name?	
First Name	
Middle Initial	
Last Name	
Suffix	
<b>Social Security Number (SSN) Information</b>	
Social Security Number	670-32-6330
If this person doesn't have a Social Security number (SSN), but has applied for one, when did he or she apply?	12/31/9999
<b>Ethnicity</b>	
Ethnicity	Other
<b>Race</b>	
Race	White
If this person is American Indian/Alaskan Native, are they a member of Federally recognized tribe	
If yes, tribe name	
<b>Personal Information Continued</b>	
Does this person live in Georgia?	Yes
Is this person Blind or disabled?	
Is this person United States Citizen?	Yes
<b>Immigration Information</b>	

What is person's Immigration status?	
When did this person come to US to live?	
What is this person's Immigration document type?	
What is this person's Alien registration number?	
<b>Military Information</b>	
Are you a veteran or active duty member?	No
Is your spouse a veteran or active duty member?	No
If you are applying on behalf of a child, is the parent of the child in the home a veteran or an active duty member?	No
When did this information change?	

<b>People In Your Home- CRISTINA ROSAS-JAIME</b>	
<b>Personal Information</b>	
First Name	CRISTINA
Middle Initial	M
Last Name	ROSAS-JAIME
Suffix	--
Gender	Female
Date of Birth	12/27/2008
What is the primary language of household?	English
Other Language	
If an interview is needed do you need an interpreter?	
Do you need assistance while communicating with us	
Other type of help communicating	
What is this person's Marital Status?	Never Married
What is this person's Living Arrangement?	In This Home
If person is living out of home, what is the reason?	
Does this person intend to file taxes?	No
Is this person claimed as a dependent by someone living outside of the home?	No
<b>Program Selection</b>	
Programs	Medical Assistance
<b>Alternative Name Information</b>	
Is this person known by any other name?	
First Name	
Middle Initial	
Last Name	
Suffix	
<b>Social Security Number (SSN) Information</b>	
Social Security Number	672-40-6231
If this person doesn't have a Social Security number (SSN), but has applied for one, when did he or she apply?	12/31/9999
<b>Ethnicity</b>	
Ethnicity	Other
<b>Race</b>	

Race	White
If this person is American Indian/Alaskan Native, are they a member of Federally recognized tribe	
If yes, tribe name	
<b>Personal Information Continued</b>	
Does this person live in Georgia?	Yes
Is this person Blind or disabled?	
Is this person United States Citizen?	Yes
<b>Immigration Information</b>	
What is person's Immigration status?	
When did this person come to US to live?	
What is this person's Immigration document type?	
What is this person's Alien registration number?	
<b>Military Information</b>	
Are you a veteran or active duty member?	No
Is your spouse a veteran or active duty member?	No
If you are applying on behalf of a child, is the parent of the child in the home a veteran or an active duty member?	No
When did this information change?	

<b>Declaration of Citizenship</b>	
Children Name	BRIANA CALDERON, BRIGGS ROSAS, CRISTINA ROSAS-JAIME
I attest to the citizenship/immigration of the child/ children listed above and certify under the penalty of perjury, that the information written and checked above is true	
Adult Name	PAULA ROSAS-JAIME
Do you attest to Individual's citizenship/Immigration status?	No
First Name	
Middle Initial	
Last Name	
Suffix	

<b>Planning for Healthy Babies</b>	
Is able to have baby?	
If we cannot decide you are eligible for any other Medical Assistance benefit, do you want us to look at whether you are eligible for Planning for Healthy Babies(P4HB)? P4HB ONLY provides family planning related benefits to women, not full Medical benefits. It does not meet the requirement for Minimum Essential Coverage when filing your taxes.	
Has delivered a baby weighing 3.3lbs or less than (1500 grams)?	



Relationship Information - CHESTER SEALE	
Relationships	CHESTER is the spouse of PAULA CHESTER is the father of BRIANA CHESTER is the father of BRIGGS CHESTER is the father of CRISTINA
When did this information change?	

Relationship Information - PAULA ROSAS-JAIME	
Relationships	PAULA is the mother of BRIANA PAULA is the mother of BRIGGS PAULA is the mother of CRISTINA
When did this information change?	

Relationship Information - BRIANA CALDERON	
Relationships	BRIANA is the sister of BRIGGS BRIANA is the sister of CRISTINA
When did this information change?	

Relationship Information - BRIGGS ROSAS	
Relationships	BRIGGS is the brother of CRISTINA
When did this information change?	

Pregnancy Details -	
Due date?	
How many babies are expected from this pregnancy?	

Tax Details – CHESTER SEALE	
Tax Return	
Does this person intend to file taxes jointly with spouse?	
Tax dependents	BRIANA CALDERON,BRIGGS ROSAS,CRISTINA
Does this person intend to claim tax dependents that do not live in the household?	No
When did this information change?	
Tax Dependents and Joint Filers Outside Household	
First Name	
Last Name	
Date of Birth	
Social Security Number	
Relationship	
Average Monthly Earned Income	
Average Monthly Unearned Income	
Is this person pregnant?	
If yes, number of babies expected?	
When did this information change?	
Tax Claim Dependent of Someone Outside Household	

First Name	
Last Name	
Relationship to the person outside of the home claiming person as a dependent	
When did this information change?	
<b>Relationship Information -</b>	
Relationships	

<b>Tax Details – PAULA ROSAS-JAIME</b>	
<b>Tax Return</b>	
Does this person intend to file taxes jointly with spouse?	
Tax dependents	BRIANA CALDERON,BRIGGS ROSAS,CRISTIN
Does this person intend to claim tax dependents that do not live in the household?	No
When did this information change?	
<b>Tax Dependents and Joint Filers Outside Household</b>	
First Name	
Last Name	
Date of Birth	
Social Security Number	
Relationship	
Average Monthly Earned Income	
Average Monthly Unearned Income	
Is this person pregnant?	
If yes, number of babies expected?	
When did this information change?	
<b>Tax Claim Dependent of Someone Outside Household</b>	
First Name	
Last Name	
Relationship to the person outside of the home claiming person as a dependent	
When did this information change?	
<b>Relationship Information -</b>	
Relationships	

<b>Tax Details – BRIANA CALDERON</b>	
<b>Tax Return</b>	
Does this person intend to file taxes jointly with spouse?	
Tax dependents	
Does this person intend to claim tax dependents that do not live in the household?	No
When did this information change?	
<b>Tax Dependents and Joint Filers Outside Household</b>	
First Name	

Last Name	
Date of Birth	
Social Security Number	
Relationship	
Average Monthly Earned Income	
Average Monthly Unearned Income	
Is this person pregnant?	
If yes, number of babies expected?	
When did this information change?	
Tax Claim Dependent of Someone Outside Household	
First Name	
Last Name	
Relationship to the person outside of the home claiming person as a dependent	
When did this information change?	
Relationship Information -	
Relationships	

Tax Details – BRIGGS ROSAS	
Tax Return	
Does this person intend to file taxes jointly with spouse?	
Tax dependents	
Does this person intend to claim tax dependents that do not live in the household?	No
When did this information change?	
Tax Dependents and Joint Filers Outside Household	
First Name	
Last Name	
Date of Birth	
Social Security Number	
Relationship	
Average Monthly Earned Income	
Average Monthly Unearned Income	
Is this person pregnant?	
If yes, number of babies expected?	
When did this information change?	
Tax Claim Dependent of Someone Outside Household	
First Name	
Last Name	
Relationship to the person outside of the home claiming person as a dependent	
When did this information change?	
Relationship Information -	

Relationships	
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<b>Tax Details – CRISTINA ROSAS-JAIME</b>	
<b>Tax Return</b>	
Does this person intend to file taxes jointly with spouse?	
Tax dependents	
Does this person intend to claim tax dependents that do not live in the household?	No
When did this information change?	
<b>Tax Dependents and Joint Filers Outside Household</b>	
First Name	
Last Name	
Date of Birth	
Social Security Number	
Relationship	
Average Monthly Earned Income	
Average Monthly Unearned Income	
Is this person pregnant?	
If yes, number of babies expected?	
When did this information change?	
<b>Tax Claim Dependent of Someone Outside Household</b>	
First Name	
Last Name	
Relationship to the person outside of the home claiming person as a dependent	
When did this information change?	
<b>Relationship Information -</b>	
Relationships	

<b>Caretaker/ Non-Parent –</b>	
Primary caretaker	

<b>Absent Parent –</b>	
What is the reason for parent's absence?	
<b>Absent Parent Details</b>	
First Name	
Middle Initial	
Last Name	
Date of Birth	
Social Security Number	
<b>Absent Parent Address</b>	
Address Line1	

Address Line2	
City	
State	
Zip Code	
Phone Number	
<b>Absent Parent Employment Information</b>	
Employer Name	
Address Line1	
Address Line2	
City	
State	
Zip Code	
Employer Phone	
<b>Cooperation with Child Support</b>	
Would you like to claim Good Cause before the worker contacts the Child Support Services?	
Is the absent parent court ordered to pay child support?	

<b>Other Household Questions</b>	
Children under age 18 who have special needs.	
Anyone who aged out of foster care at age 18 or older.	
Children in the house currently in foster care.	
Anyone in the independent living program.	
Anyone who is a fugitive felon	
Anyone who is a convicted felon?	
Is anyone trying to avoid prosecution or jail for a felony?	
Anyone violating conditions of probation or parole	

<b>Convicted Felon Details -</b>	
Type of conviction	
Date of conviction	
When did this information change?	

<b>Traded or sold benefits for drugs after 8/22/96</b>	
When was this person convicted for Traded or sold benefits for drugs after 8/22/96?	

<b>Falsified residency or identity after 8/22/96</b>	
When was this person convicted for Falsified residency or identity after 8/22/96?	
Where was this person convicted for Falsified residency or identity after 8/22/96? City	

Where was this person convicted for Falsified residency or identity after 8/22/96? State	
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Trafficked benefits of \$500 or more after 8/22/96	
When was this person convicted for Trafficked benefits of \$500 or more after 8/22/96?	

Possessed or distributed controlled substance (drugs)	
When was this person convicted for Possession or distribution of controlled substance (drugs)?	

Sold or received benefits for firearms, ammunition, or explosives after 8/22/96	
When was this person convicted for Selling or receiving benefits for firearms, ammunition, or explosives after 8/22/96?	

Used benefits at unauthorized retailer (liquor store, gambling establishment, etc.) after 6/1/12	
When was this person convicted for Using benefits at unauthorized retailer (liquor store, gambling establishment, etc.) after 6/1/12?	

Out of State Benefit Details -	
Out of State Food Stamps (SNAP) Benefits	
State	
Is this person still receiving Food Stamp (SNAP) Benefits in this state?	
What was the last date Food Stamp (SNAP) Benefits were received from this state?	
Out of State Medical Assistance Benefits	
State	
Is this person still receiving Medical Assistance Benefits in this state?	
What was the last date Medical Assistance Benefits were received from this state?	
Out of State TANF Benefits	
State	
Is this person still receiving TANF Benefits in this state?	
What was the last date TANF Benefits were received from this state?	
When did this information change?	

Other Benefits	
Anyone who used to get Supplemental Security Income (SSI), but is no longer getting the benefit.	
Anyone currently receiving Community Care Services (CCSP) from the division of Aging	
Anyone for whom you wish to apply for Katie Beckett Medicaid.	
Anyone who has received health services from the Indian Health Services, a tribal health program, an urban Indian Health program, or through a referral from one of these programs.	
Anyone who is eligible to receive health services from the Indian Health Services, a tribal health program, an urban Indian Health program, or through a referral from one of these programs.	
Anyone who received Emergency Medical care in the last 3 months.	

Medicare Part A or B Details -	
Is this person entitled to or receiving Medicare Part A?	
Medicare Part A begin date.	
Is this person entitled to or receiving Medicare Part B?	
Medicare Part B begin date.	
Medicare Claim Number	
When did this information change?	

Health Insurance Details -	
What type of health insurance does this person have?	
Who is covered by this health insurance?	
When did this information change?	

Other Insurance Details -	
Name of Health Insurance Company	
Policy Number	
Is this a limited benefit plan (like a school accident policy)	

Hospital Stay Details -	
Hospital name	
When did this information change?	

Lost Health Insurance Details -	
Reason Health Insurance Was Lost	
Last Day of Health Insurance	
When did this information change?	

Hospice Care Details -	
Hospice Care Facility Name	
When did this information change?	

Nursing Home Details -	
Name of Nursing Home	
ProviderID	
Level of care met?	
Where was USER admitted from	
Nursing home admission date	
Hospital admission date	
Does USER receive hospice in nursing home?	
Hospice provider name	
Why did USER's nursing home stay end?	
Discharge destination	
Other discharge destination	
When did USER's nursing home stay end?	
When did this information change?	

Cash Details -	
How much cash does this person have?	
Other Owners	
If other owners, please enter the percentage that this person owns.	
When did this information change?	

Financial Account Details - CHESTER SEALE	
Financial Account	
Account type	Checking Account
Value of financial account	\$200.00
Bank or Company	
Bank or Company Name	BANK
Address Line1	
Address Line2	
City	
State	
Zip Code	
Financial account number	



Other Owners	
Percentage that this person owns.	
When did this information change?	

<b>Other Liquid Resources Details -</b>	
<b>Trust Fund</b>	
Trust Fund type	
Trust Fund value	
Is Trust Fund irrevocable or revocable	
<b>Bank or Company</b>	
Name of Bank or Company	
Address Line1	
Address Line2	
City	
State	
Zip Code	
Trust Fund account number	
Other Owners	
Percentage that this person owns	
When did this information change?	

<b>Sold, Traded, Given Away Resources -</b>	
Resource Type	
Date Resource Received	
Date resource was sold, traded, or given away	
Value of the resource at the time it was sold, traded, or given away	
Amount received	
When did this information change?	

<b>Vehicle Details -</b>	
Vehicle Type	
Year	
Make	
Model	
How much does this person owe on this vehicle?	
Value of Car	
Other Owners	
If other owners, please enter the percentage that this person owns.	
When did this information change?	

<b>Real Estate Details -</b>	
Real Estate Type	
Does this person live here?	
How much is owed on this real estate	
Value of this Real Estate	
Address Line1	

Address Line2	
City	
State	
Zip Code	
Other Owners	
If other owners, please enter the percentage that this person owns.	
When did this information change?	

<b>Burial Resource Details -</b>	
Value of Burial Resource	
Other Owners	
Percentage that this person owns	
When did this information change?	

<b>Life Insurance Details -</b>	
Life Insurance Type	
Face value of this policy	
Cash surrender value of this policy	
What is the policy number?	
<b>Life Insurance Company</b>	
Name	
Address Line1	
Address Line2	
City	
State	
Zip Code	
Phone	
Other Owners	
Percentage that this person owns	
When did this information change?	

<b>Other Resource Details -</b>	
Other Resource Type	
Worth	
How much is paid for this Other Resource	
Contents of other resource?	
Other Owners	
Percentage that this person owns	
When did this information change?	

<b>Current Job Details -</b>	
<b>Employer Details</b>	
Employer Name	
Employer Identification Number (EIN)	
Address Line1	
Address Line2	
City	

State	
Zip Code	
Employer's Phone Number	
Currently on strike	
Has job ended	
When did this job start	
Date of First Pay	
<b>End of Job Details</b>	
When did this job end	
Date of final paycheck	
Gross amount of final paycheck	
<b>Payment Information</b>	
How often does this person get paid?	
Gross amount paid each pay period	
Hours worked each pay period	
Hourly pay rate	
<b>Additional Information</b>	
Additional comments about your job	
When did this information change?	

<b>Employer Offered Health Coverage Details -</b>	
Is this a COBRA Coverage	
Is this a retiree health plan	
Is this a state employee benefit plan	
Enrolled in the health coverage offered by your employer	
Name of Health Insurance Company	
Policy Number	
Employer Contact Name	
Employer Contact Phone Number	
Employer Contact Email Address	
Will you be eligible for employer health coverage in the next three months	
If yes, start date	
Does the employer offered coverage meet the minimum value standard	
How often will the premium be paid	
Will the employer offered coverage change next year	
Premium for new plan	
How often will the premium be paid	
Date of change	
Other Owners	
Percentage that this person owns.	

<b>Self-Employment Details -</b>	
Name of business	

Type of self-employment	
Gross monthly income amount from self-employment before any taxes, deductions, or expenses are taken out	
Hours self-employed a week	
When did this information change?	

DCSS Child Support Income Details -	
When did DCSS Child Support Income begin?	
How often are payments from DCSS Child Support Income?	
Gross income from DCSS Child Support Income	
When did this information change?	

Direct Child Support Income Details -	
When did direct child support payments begin	
How often are direct child support payments	
How much is each gross direct child support payment	
When did this information change?	

Supplemental Security Income (SSI) Income Details -	
When did payments from Supplement Security Income (SSI) begin	
How often are payments from Supplement Security Income (SSI)	
Gross payment from Supplemental Security Income (SSI)	
When did this information change?	

Social Security/RSDI Income Details -	
When did payments from Social Security/RSDI begin	
How often are payments from Social Security/RSDI	
How much is each gross payment from Social Security/RSDI	
Social Security/RSDI Claim Number	
When did this information change?	

Veterans Benefits Income Details -	
Type of Veterans Benefits	
When did payments from Veterans Benefits begin?	
How often are payments from Veterans Benefits	
Gross payment from Veterans Benefits	
When did this information change?	

Contributions Income Details -	
When did payments from Contributions begin	
How often are payments from Contributions	
Amount of the Contribution received	
When did this information change?	

Other Types of Income Details - CHESTER SEALE	
Other Income Type	Pension
When did payments from Other Income begin	08/22/2017
How often are payments from Other Income	Monthly
How much is each payment from Other Income	\$416.75
Other Income Details	
Type of Other Income	
When did payments from Other Income begin	
How often are payments from Other Income	
Gross payment of Other Income	
When did this information change?	

Other Types of Income Details - CHESTER SEALE	
Other Income Type	Social Security (RSDI) Survivor or Retirement Be
When did payments from Other Income begin	01/01/2020
How often are payments from Other Income	Monthly
How much is each payment from Other Income	\$1,690.00
Other Income Details	
Type of Other Income	
When did payments from Other Income begin	
How often are payments from Other Income	
Gross payment of Other Income	
When did this information change?	

Other Types of Income Details - CRISTINA ROSAS-JAIME	
Other Income Type	Social Security (RSDI) Survivor or Retirement Be
When did payments from Other Income begin	01/01/2020
How often are payments from Other Income	Monthly
How much is each payment from Other Income	\$482.00
Other Income Details	
Type of Other Income	
When did payments from Other Income begin	
How often are payments from Other Income	
Gross payment of Other Income	
When did this information change?	

Other Types of Income Details - BRIGGS ROSAS	
Other Income Type	Social Security (RSDI) Survivor or Retirement Be
When did payments from Other Income begin	01/01/2020
How often are payments from Other Income	Monthly
How much is each payment from Other Income	\$482.00

Other Income Details	
Type of Other Income	
When did payments from Other Income begin	
How often are payments from Other Income	
Gross payment of Other Income	
When did this information change?	

Other Types of Income Details - BRIANA CALDERON	
Other Income Type	Social Security (RSDI) Survivor or Retirement Be
When did payments from Other Income begin	01/01/2020
How often are payments from Other Income	Monthly
How much is each payment from Other Income	\$482.00
Other Income Details	
Type of Other Income	
When did payments from Other Income begin	
How often are payments from Other Income	
Gross payment of Other Income	
When did this information change?	

American Indian/ Alaskan Native Income Details -	
When did American Indian/ Alaskan Native Income begin ?	
How often is American Indian/ Alaskan Native Income received?	
Amount of American Indian/ Alaskan Native Income received?	
When did this information change?	

Housing Bills Details - CHESTER SEALE	
Housing Bill Type	Mortgage
How often does this person pay for this housing?	Monthly
How much is the total housing bill	\$899.01
How much does this person pay for the housing bill?	\$899.01
Landlord/Property Information	
Landlord/Property Name	CITI MORTGAGE
Address Line1	
Address Line2	
City	
State	
Zip Code	
When did this information change?	

Utility Bill Details	
Utility Bill Type	
Utility Bill Total Amount	\$0.00
Utility Bill Amount Paid	\$0.00

Heating Cooling Source	
When did this information change?	

Prior Month Medical Bills -	
Unpaid Prior Months:	

Child and Adult Care Details -	
Provider Name	
Address Line1	
Address Line2	
City	
State	
Zip Code	
Phone	
Reason paying for care	
Child or adult for whom care is paid	
Payment Start Date	
How often is the payment made	
How much is each payment	
When did this information change?	

Child Support Details -	
Amount court ordered to pay for child support	
Amount currently paying for child support	
How often is Child Support paid	
Name of the child receiving child support	
When did this information change?	

Before Tax Deduction Details -	
Medical Insurance	
Dental Insurance	
Vision Care Insurance	
Flexible Spending Accounts (Health and Dependent Plans)	
Deferred Compensation	
Pre-tax Life Insurance Premiums	
Other	

Income Tax Deduction Details -	
Educator Expenses	
Business Expenses of Reservists, Performing Artists, and Free-Basis Government Officials	
Health Savings Account Deduction	
Moving Expense	
Deductible Part of Self-Employment Tax:	
Self Employed SEP, SIMPLE and Qualified Plans	
Self Employed Health Insurance Deductible	

Penalty on Early Withdrawal of Servings	
Alimony Paid	
IRA Deduction	
Student Loan or Interest Deduction	
Tuition and Fees	
Domestic Production Activities Deductions	
When did this information change?	

Medical Bills Details - CHESTER SEALE	
Medical Bills Type	Other
How much is paid for this medical bill?	0
How often is this medical bill paid?	Monthly
When did this information change?	

School Enrollment Details - CHESTER SEALE	
Is this a federal or state funded work-study program	
When did this information change?	

School Enrollment Details - BRIANA CALDERON	
Is this a federal or state funded work-study program	
When did this information change?	

School Enrollment Details - BRIGGS ROSAS	
Is this a federal or state funded work-study program	
When did this information change?	

School Enrollment Details - CRISTINA ROSAS-JAIME	
Is this a federal or state funded work-study program	
When did this information change?	

Authorized Representative Details	
Name of the Authorized Representative	
Organization Name	
ID Number	
Address Line1	
Address Line2	
City	
State	
Zip Code	
Phone Number	
Relationship to Applicant	

Signing Your Application Details	
Would you like to register to vote today	
Citizenship Agreement Complete	Yes
Renewal of Coverage in Future Years	Don't use information from tax returns to renew my coverage.



Electronically Signed	Yes
Signed By	Chester Seale

HIPAA Notice of Privacy Practices  
Georgia Department of Human Services

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact:

Georgia Department of Human Services

HIPAA Privacy Officer  
HIPAADHS@dhs.ga.gov  
(404) 657-9761 phone  
(404) 657-1123 fax

The Department of Human Services (DHS) is an agency of the Executive Branch of Georgia government charged with the administration of numerous federal programs responsible for the storage, use and maintenance of medical and other confidential information. Federal and state laws establish strict requirements for these programs regarding the use and disclosure of confidential and protected information. DHS is required to comply with those laws as noted throughout this Notice.

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

- Maintain the privacy of protected health information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice currently in effect.

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways DHS may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, DHS will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to the HIPAA Privacy Officer at the contact information above.

**For Treatment.** DHS may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, DHS may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in your medical care and need the information to provide you with medical care.

**For Payment.** DHS may use and disclose Health Information so that DHS or others may bill and receive payment related to your care, an insurance company, or a third party for the treatment and services you received. For example, DHS may provide your health plan information so that treatment may be paid for.

**For Health Care Operations.** DHS may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that quality care is received and to operate, manage, and administer the functions of the agency. For example, DHS may use and disclose information to make sure the medical care you receive is of the highest quality. DHS also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.** DHS may use and disclose Health Information to contact you to remind you of an appointment with a physician. DHS also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, DHS may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. DHS also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, DHS may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before DHS uses or discloses Health Information for research, the project will go through a special approval process. Even without special approval, DHS may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

#### SPECIAL SITUATIONS:

**As Required by Law.** DHS will disclose Health Information when required to do so by international, federal, state or local law.

**To Avert a Serious Threat to Health or Safety** . DHS may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**Business Associates.** DHS may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, DHS may utilize the services of a separate entity to perform billing services. All DHS business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Organ and Tissue Donation.** If you are an organ donor, DHS may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, DHS may release Health Information as required by military command authorities. DHS also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Workers Compensation.** DHS may release Health Information for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** DHS may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if it is believed a patient has been the victim of abuse, neglect or domestic violence. DHS will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** DHS may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Data Breach Notification Purposes.** DHS may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, DHS may disclose Health Information in response to a court or administrative order. DHS also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** DHS may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** DHS may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. DHS also may release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** DHS may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** DHS may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, DHS may release Health Information to the

correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

#### USES AND DISCLOSURES THAT REQUIRE DHS TO PROVIDE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, DHS may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, DHS may disclose such information as necessary if it is determined that it is in your best interest based on the professional judgment of DHS.

Disaster Relief. DHS may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. DHS will provide you with an opportunity to agree or object to such a disclosure whenever it is practical to do so.

#### YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to DHS will be made only with your written authorization. If you do provide DHS an authorization, you may revoke it at any time by submitting a written revocation to the above-referenced Privacy Officer. Upon receipt, DHS will no longer disclose Protected Health Information under the authorization. However, disclosures made in reliance upon your authorization before you revoked it will not be affected by the revocation.

#### YOUR RIGHTS:

You have the following rights regarding Health Information DHS has about you:

**Right to Inspect and Copy.** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the above referenced HIPAA Privacy Officer. DHS has up to 30 days to make your Protected Health Information available to you and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

**Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. DHS will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format. If you do not want this form or format, a readable hard copy form will be provided. DHS may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

**Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

**Right to Amend.** If you feel that Health Information DHS has is incorrect or incomplete, you may request DHS to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures DHS made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information DHS uses or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information DHS discloses to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that DHS not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer. DHS is not required to agree to your request unless you are requesting DHS restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid 'out-of-pocket' in full. If DHS agrees, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communications.** You have the right to request that DHS communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that DHS only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer. Your request must specify how or where you wish to be contacted. DHS will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may request a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the above-referenced HIPAA Privacy Officer.

#### CHANGES TO THIS NOTICE:

DHS reserves the right to change this notice and make the new notice apply to Health Information already obtained as well as any information received in the future. DHS will post a copy of the current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

#### COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint, in writing, by contacting the above-referenced HIPAA Privacy Officer. You will not be penalized for filing a complaint.

You may also file with the Secretary of the Department of Health and Human Services. For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, <http://www.acog.org> or call (202) 863-2584.

#### NON-DISCRIMINATION:

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

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

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

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027), found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

You may also file a complaint of discrimination by contacting the DFCS Civil Rights Program, Two Peachtree Street, N.W., Suite 19-248, Atlanta, Georgia 30303 or call (404) 657-3735 or fax (404) 463-3978. For limited English proficient and sensory impaired services, contact the DHS Limited English Proficiency and Sensory Impaired Program at: Two Peachtree Street, N.W., Suite 29-103 N.W., Atlanta, GA 30303 or call (404)-657-5244 or fax (404)-651-6815.

**Under the Department of Community Health (DCH) policy**, Medicaid 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.

#### Electronic Signature

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

I have read, understand, and acknowledge receipt of the DHS HIPAA Notice of Privacy Practices

Electronically Signed	Yes
Signed By	Chester B Seale Jr



## Food Stamp Rights and Responsibilities

Please read the following information carefully.

### YOU HAVE THE RIGHT TO

- receive an application on the day you ask for it.
- have your application accepted when you file it.
- have an adult apply for your household if you are unable to.
- a telephone interview.
- receive fair treatment without regard to age, sex, race, color, handicap, religious creed, national origin, or political beliefs.
- have a fair hearing if you disagree with any action on your case.
- examine your case file and the rules of the program.
- be notified in advance if your benefits are reduced or stopped due to a change that is not reported in writing.

### YOUR RESPONSIBILITIES

- you must answer all questions completely.
- you must sign your name to certify, under penalty of perjury, that all answers are true.
- you must provide proof that you are eligible.
- 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 are a single working adult with no children, you must also report when your work hours fall below 20 hours a week or 80 hours per month.
- Do not give false information or hide information to get benefits that your household should not get.
- Do not sell, trade, or give away your food stamp benefits.
- use food stamp benefits to buy only eligible items.
- Food Stamp households CANNOT use their benefits to purchase non-food items such as beer, wine, liquor, cigarettes, tobacco, pet foods, soaps, paper products and household supplies.
- Food Stamp households also ARE NOT allowed to purchase food on credit with their benefits."

### PENALTIES

- Any household member who breaks any of the food stamp rules on purpose can be barred from the Food Stamp Program for one year to permanently, fined up to \$250,000, imprisoned up to 20 years or both. She/he may also be subject to prosecution under other applicable Federal and State laws. She/he may also be barred from the Food Stamp Program for an additional 18 months if court ordered.
- Any household member who intentionally breaks the rules may not get Food Stamps for

one year for the first offense, two years for the second offense, and permanently for the third offense.

- If a court of law finds you or any household member guilty of using or receiving Food Stamp benefits in a transaction involving the sale of a controlled substance, you or that household member will not be eligible for benefits for two years for the first offense, and permanently for the second offense.
- If a court of law finds you or any household member guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives, you or that household member will be permanently ineligible to participate in the Food Stamp Program upon the first offense of this violation.
- If a court of law finds you or any household member guilty of having trafficked benefits for an aggregate amount of \$500 or more, you or that household member will be permanently ineligible to participate in the Food Stamp Program upon the first offense of this violation.
- If you or any household member is found to have given a fraudulent statement or representation with respect to identity (who they are) or place of resident (where they live) in order to receive multiple Food Stamp benefits, you or that household member will be ineligible to participate in the Food Stamp Program for a period of 10 years.
- For more information about Community Outreach Services, please visit our website at: <http://www.dfcs.dhr.georgia.gov> or call 1-877-423-4746

#### IN ALL PROGRAMS YOU HAVE THE RIGHT TO

- request a fair hearing in writing or in person. You have the right to be represented by a household member, legal counsel, a relative, a friend or other spokesperson. If you are not satisfied with the action we have taken on your case, you can request a hearing by contacting the county office where you applied for benefits or by calling 1-877- 423-4746.
- review some of the material and information in your case file. However, you may not be able to see all of the information in the case file, such as names of people who have given us information about you or your household members or information about any criminal prosecutions involving you or any of your household members.
- decide if you want to provide a Social Security Number (SSN), citizenship, or immigration status. Only the people who give information to us about their SSN, citizenship, or immigration status will be eligible to receive benefits. This information will be used to check the "Income and Eligibility Verification System" (IEVS) and other computer matches with other agencies to verify your income and other points of eligibility. We may also give this information to other Federal and State agencies to review and to law enforcement officials for them to use in catching people who are running from the law. If your household has a Food Stamp or SNAP claim, the information on this application, including the SSN, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim. We will not share your information with the United States Citizenship and Immigration Services (USCIS); however, if alien status information has been submitted on your application, this information may be subject to verification through USCIS and may affect your household's eligibility and benefit level. We will not deny help to people asking for help because other household members do not provide their SSN, citizenship, or immigration status. The following federal laws and regulations: 7 U.S.C. § 2011-2036, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, 42 C.F.R. § 435.920, authorize DFCS to request your and your household members social security number(s).

- decide if you want to provide information about your race and ethnicity. We collect data on race, color, and national origin to ensure we are in compliance with Federal civil rights laws. By providing this information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information and it will not affect your eligibility or benefit level.

#### IN ALL PROGRAMS, YOU ARE RESPONSIBLE FOR

- giving your worker correct information and providing proof of statements needed to receive benefits. When you sign this form, you are giving your worker permission to get information from your employer, bank, neighbor or others so we can make sure you are receiving the correct amount of benefits.
- telling the truth at all times. If you or someone who is applying for you provides incorrect information, you may 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 eligible immigrant. Note: Your worker will give you a list of the ways you can prove your citizenship or immigration status. WIC does not require citizenship or immigration status to determine your eligibility for the program. For Child Care, you are responsible for providing proof that any child applying for benefits is a U.S. citizen or qualified alien.
- reporting certain changes in your household situation. Each program has different reporting requirements. See the responsibilities section for each program for things you need to report.

#### Medicaid Rights and Responsibilities

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 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.

In Medical Assistance program you also have to report changes about you and the other people in your Medical Assistance case within 10 days; please report:

- if you or other household members move
- if you or other household members change jobs, get a new job, quit a job or get laid off.
- if you or other household members have a change in income or resources
- if a family member moves in or out of your home
- if you or another household member inherits or receives money or property from any source
- if someone in your home dies or gets married

- any other changes tell your case manager when your pregnancy ends. Pregnancy ends with the birth of the baby, a miscarriage or an abortion. You must report the end of the pregnancy within 10 days.

In all programs, you are responsible for

- giving your worker correct information and providing proof of statements needed to receive benefits. When you sign this form, you are giving your worker permission to get information from your employer, bank, neighbor or others so we can make sure you are receiving the correct amount of benefits.
- telling the truth at all times. If you or someone who is applying for you provides incorrect information, you may 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 eligible immigrant. Note: Your worker will give you a list of the ways you can prove your citizenship or immigration status. WIC does not require citizenship or immigration status to determine your eligibility for the program. For Child Care, you are responsible for providing proof that any child applying for benefits is a U.S. citizen or qualified alien.
- reporting certain changes in your household situation. Each program has different reporting requirements. See the responsibilities section for each program for things you need to report.

#### Child Care Rights and Responsibilities

The information you share with the eligibility authority is confidential. This means that what you tell the eligibility authority cannot be shared with anyone other than the Department of Human Services (DHS) without your permission except for officially designated program review agents.

You have a right to see your case file unless this is prohibited by Federal or State law or regulation

You have a right not to be discriminated against because of political affiliation, religion, race, color, sex, handicap, national origin or age. Should a problem arise about your application, placement or change in service, DHS will address it promptly. If you are still not satisfied, you may call 1-877-423-4746 (this is a free call) or file for an Administrative Hearing.

You have a right to file an appeal if your fee increases or your assistance is stopped and you do not agree with this decision. Your case manager will help you file an appeal if you wish to do so.

I understand that I may receive child care service as long as funds are available and I remain eligible and have complied with all CAPS program requirements

I certify that this application for services has been examined by me and that the information given is true and correct to the best of my knowledge and belief.

I agree to provide such information as I can to the eligibility authority for the purpose of determining eligibility for assistance.

I agree to provide the eligibility authority with information to verify any statements given in this application and hereby give permission to obtain such verification. I will cooperate fully with State and Federal personnel in a quality control review.

I understand that I am receiving child care because I am, low income, working, in school or in vocational/technical training and in need of child care. It is my responsibility to report any changes in my circumstances to the eligibility authority within 10 calendar days of becoming aware of the change.

I understand that child care in support of education and training requires me to be enrolled in an approved program, attend and to maintain passing grades.

I agree to pay my child care fees to the provider, if applicable.

I understand that if I fail to pay my child care fee my CAPS case will be closed.

I understand that my child should attend the child care program regularly. If my child must be absent, I should give the provider as much advance notice as possible. I also understand that some providers may request signed statements of absences.

I agree to report within 10 calendar days if my child(ren) is (are) no longer enrolled in child care or moves out of my home, or if the absent parent(s) of the child(ren) returns to the home.

#### WIC Rights and Responsibilities

- I understand that the rules for signing up and taking part in the Georgia WIC Program are the same for everyone, regardless of race, color, national origin, sex, age, or disability.
- I certify that the information I will provide, or have provided, is correct to the best of my knowledge.
- I understand that if I or someone who is applying for me intentionally makes a false or misleading statement or intentionally misrepresents, conceals, or withholds facts, you may be subject to civil or criminal prosecution under State and Federal law.
- I understand and agree that the Program may verify the information provided on this application and other documentation submitted to confirm eligibility.
- I understand that I may be denied certification if:
  - I am untruthful about eligibility criteria
  - I attempt to get certified at more than one WIC clinic at the same time
  - I do not keep your certification appointments
  - I threaten, use abusive language with, or are physically violent with WIC clinic staff, state WIC staff, or other WIC clients
  - I commit any crime in the WIC clinic or on the grounds of the clinic
  - My designated proxy engages in any of the behaviors listed above

#### TANF Rights and Responsibilities

In the TANF Program, you are responsible for:

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

What are the penalties in the TANF Program

<u>In the TANF program there are penalties: if you</u>	<u>You will lose TANF Benefits</u>
<ul style="list-style-type: none"> <li>• hide information, do not report changes on time or do not tell the truth</li> </ul>	<ul style="list-style-type: none"> <li>• for 6 months for the first violation; for 12 months for the second violation; permanently for the third violation</li> </ul>
<ul style="list-style-type: none"> <li>• hide information, do not report changes on time or do not tell the truth and are convicted in the court of law</li> </ul>	<ul style="list-style-type: none"> <li>• for 6 months for the first violation; for 12 months for the second violation; permanently for the third violation</li> </ul>
<ul style="list-style-type: none"> <li>• give false information about where you live so you can receive benefits in more than one state and are convicted on or after 01/01/1997</li> </ul>	<ul style="list-style-type: none"> <li>• for 10 years</li> </ul>

<ul style="list-style-type: none"> <li>Individuals convicted of other IPV's committed on or after 07/01/1998</li> </ul>	<ul style="list-style-type: none"> <li>for 6 months for the first violation; for 12 months for the second violation; permanently for the third violation</li> </ul>
<ul style="list-style-type: none"> <li>are convicted of a drug-related charge or a serious violent felony, on or after 01/01/1997</li> </ul>	<ul style="list-style-type: none"> <li>permanently</li> </ul>
Individuals convicted of other IPV for using cash assistance funds or the TANF EBT transactions performed at prohibited places on or after 06/01/2012	for 6 months for the first violation; for 12 months for the second violation; permanently for the third violation

#### What Other Rights Do I Have in the TANF Program?

In the TANF Program, you have a right to:

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

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

In all programs, you are responsible for:

- giving your worker correct information and providing proof of statements needed to receive benefits. When you sign this form, you are giving your worker permission to get information from your employer, bank, neighbor or others so we can make sure you are receiving the correct amount of benefits.
- telling the truth at all times. If you or someone who is applying for you provides incorrect information, you may lose your benefits or be subject to criminal prosecution for knowingly providing false information.
- providing proof that you or anyone in your household applying for benefits is a U.S. citizen or qualified immigrant. Note: Your worker will give you a list of the ways you can prove your citizenship or immigration status.
- reporting certain changes in your household situation. Each program has different reporting requirements. See the responsibilities section for each program for things you need to report.

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

In all programs, you have the right to:

- request a fair hearing in writing or in person. You have the right to be represented by a household member, legal counsel, a relative, a friend or other spokesperson. If you are not satisfied with the action we have taken on your case, you can request a hearing by contacting the county office where you applied for benefits or by calling 1(XXX) XXX-XXXX.
- 90 days from the date of this notice for Food Stamps
- 30 days from the date of this notice for Medicaid and TANF
- review some of the material and information in your case file. However, you may not be able to see all of the information in the case file, such as names of people who have given us information about you or your household members or information about any criminal prosecutions involving you or any of your household members.

- decide if you want to provide Social Security Number (SSN), citizenship, or immigration status information. To qualify for public assistance, individuals must be a U.S. citizen, U.S. National, or eligible immigrant. Pursuant to the Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7. C.F.R. § 273.2, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, DFCS is authorized to request your and your household members SSN.

Individuals who are applying for public assistance must provide or apply for an SSN, and/or verify their citizenship or immigration status. Some immigrants are eligible and some are not, depending on their legal status. If you or anyone in your household does not have an SSN, we can help you apply for one. Applying for an SSN will not delay a decision on your application for benefits. An individual, who is not applying for public assistance and who does not provide an SSN, citizenship or immigrant status may be designated as a non-applicant.

A non-applicant is not required to provide an SSN, citizenship, or immigrant status but is required to provide other information that may affect the eligibility of other applicant household members such as income or resources. A non-applicant is not eligible to receive benefits. Only the people who give information to us about their SSN, citizenship, or immigration status will be eligible to receive benefits. We will use this information to check the Income and Eligibility Verification System (IEVS). We will also match your information with other Federal, state, and local agencies to verify your income and eligibility. This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a Food Stamp claim, the information on this application, including SSNs, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim. We will not share your information with the United States Citizenship and Immigration Services (USCIS); however, if immigration status information has been submitted on your application, this information may be subject to verification through USCIS and may affect your household's eligibility and benefit level. We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status. Applying for or receiving Food Stamp benefits does not make a non-citizen a public charge. Receiving or accepting Supplemental Security Income (SSI), TANF cash assistance, Institutionalized Long Term Care Medicaid, or state General Assistance could make a non-citizen a public charge if all eligibility criteria are met. However, receiving these benefits does not automatically make an individual inadmissible or ineligible to adjust his/her status to lawful permanent resident on a public charge basis. A "public charge" means you are a person who is likely to become "primarily dependent" on the government to maintain your way of life, as demonstrated by either the receipt of public cash assistance for income maintenance or by institutionalization for long-term care at the government's expense." If you are considered to be a public charge, you will not be deported, or denied permanent status because you have applied for or receive public assistance. Emergency Medicaid, including labor and delivery, is available for pregnant non-qualified and undocumented immigrants.

- decide if you want to provide information about your race and ethnicity. We collect data on race color, and national origin to ensure we are in compliance with Federal civil rights laws. By providing this information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information and it will not affect your eligibility or benefit level.

### Benefits of Child Support Services

The Division of Child Support Services (DCSS) may be able to provide the following benefits:



- finding the absent parent
- legally establishing your child's paternity
- receipt of child support payments that may give you more money than if you receive TANF
- acquisition of private health insurance through the absent parent, and
- acquisition of rights of future Social Security, veterans or other government benefits

#### Cooperation with DFCS and DCSS

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

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

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

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

#### Good Cause

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

#### If You Do Not Help and Do Not Have Good Cause

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

#### Good Cause Reasons

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

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

#### To Prove Good Cause, You Must

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

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

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

#### Examples of Proof Of Good Cause

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

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

#### Child Support Rules

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

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

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

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

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

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

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

#### Consent to Exchange Information

I understand that different state agencies provide different services and benefits. Each agency must have specific information to determine eligibility services and benefits. I understand that the Department of Human Services can disclose certain Information about me to other state agencies, including information in electronic databases, for the purpose of determining my eligibility for benefits/services provided by that agency. This disclosure will make it easier for agencies to work together efficiently to provide or coordinate services and benefits. Agencies include, but are not limited to, the Department of Public Health, the Department for the Aging, the Department of Rehabilitative Services and the Department of Vocational Rehabilitation."

The state statute that provides the legal basis for safeguarding the confidentiality of assistance-related information is the Official Code of Georgia Annotated 49-4-14. This statute restricts the use or disclosure of information concerning applicants for or recipients of public assistance to purposes directly connected to the administration of public assistance.

In addition, various Federal regulations specifically forbid the release of TANF Program information to unauthorized persons or agency representatives.

All case record material is confidential, including names and addresses of applicants and recipients (A/R), as well as the types and amounts of benefits provided.

Interviews should be conducted in a confidential setting.

Records, information and communication of the Division, including county Departments of Family and Children Services, that identify applicants for, or recipients of, cash assistance under the TANF program, are confidential and are not considered public records.

The disclosure of information concerning applicants and recipients is limited to purposes directly connected with the administration of the TANF Division, and to the administration of other federal assistance programs and federally assisted state programs which provide assistance on a means-tested basis to low-income individuals/families.

These programs include:

- Food Stamps

- Child Support
- IV-E Foster Care
- Adoption Assistance
- SSI
- Medicaid
- Office of Inspector General-Benefits Recovery Unit
- Human Services
- Social Security Administration
- IEVS, and,
- the General Office of the U.S.

The purpose of disclosing the client's information to other programs is establishing eligibility, determining the amount of benefits and providing services to the applicants and/or recipients. Information used solely for these purposes can be released without the consent of the applicant or recipient.

Childcare and Parent Services (CAPS) is a federally funded statewide program that assists families that meet program requirements to obtain and sustain self-sufficiency by subsidizing a portion of the cost of child care. The program is administered at the state level by staff at Bright from the Start: Georgia Department of Early Care and Learning (DECAL).

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

#### PEACHCARE FOR KIDS PRIVACY PROMISE TO YOU

We in the Georgia Department of Community Health (DCH) understand that health information about you and your family is private. We will protect your information. This notice tells you about your information privacy rights in the PeachCare for Kids program.

The privacy practices described in this notice will be effective August 29, 2003.

By law, PeachCare for Kids must use and disclose your child's medical information to provide information:

To you or to someone who has the legal right to act for you or your child

- To the Secretary of the U.S. Department of Health and Human Services, if necessary
- Where required by law

#### YOUR MEDICAL INFORMATION RIGHTS

You have the following rights about your child's medical information: (Note: These rights may be limited by Georgia law or by court orders.)

- You have the right to see and have a copy of your child's health information held by PeachCare for Kids. Exceptions are psychotherapy notes and information that is needed for a legal action relating to DCH.

- You have the right to ask DCH to correct your child's medical information if you think that it is wrong. DCH may deny your request in some cases.
- You have the right to ask for a copy of disclosures that DCH has made of your child's medical information starting in April 2003. The list would not include disclosures to you or to your personal representative, or for payment for your child's health care, or for PeachCare for Kids administration.
- You have the right to ask for restrictions on some uses or disclosures of your child's health information. DCH is not required to meet your request.
- You have the right to ask for DCH to contact you about your child's health in a way or at a place that will help you keep your child's information private.
- You have the right to a paper copy of this notice. You may ask for another copy of this notice, or you may get a copy from DCH's Web site, [www.dch.ga.gov](http://www.dch.ga.gov).

## PRIVACY LAW'S REQUIREMENTS

DCH is required by law to:

- Maintain the privacy of your child's medical information
- Give you this notice of DCH's legal duties and privacy practices
- Follow the terms of this notice
- Not use or disclose your child's medical information without your written authorization, except for the reasons in this notice. You may take away your authorization in writing at any time, except for information that was already disclosed

DCH may change its privacy practices. We will provide a new notice to you if there is a material change in its privacy practices. We will post the new notice on the DCH Web site at [www.dch.ga.gov](http://www.dch.ga.gov).

## HOW DCH USES AND DISCLOSES HEALTH CARE INFORMATION

PeachCare for Kids contracts with other agencies and some private companies. We may disclose some or all of your child's information to the other agency or company so that they can do the job we have asked them to do. To protect your child's information, PeachCare for Kids requires the other agency or company to safeguard the information.

Below are ways that we may use and disclose your child's health information:

**For Payment:** We may use and disclose information about your child so that we can pay for the child's health care. When your child receives medical care, the child's health care provider sends a claim to PeachCare for Kids for payment. The claim includes information that identifies your child, as well as your child's diagnoses and treatments.

**For Medical Treatment:** We may use or disclose information about your child to ensure that she or he receives needed medical care. We may send you reminders of medical appointments.

**To Operate the PeachCare for Kids Program:** We may use or disclose information about your child to manage the PeachCare for Kids program and be sure that your child receives quality care. We may contract with a company that reviews health records to check on the quality of your child's care.

To Keep You Informed: We may mail information to you about your child's health. Examples are information about managing a disease and appointment reminders.

For Overseeing Health Care Providers: We may disclose information about you to the government agencies that license and inspect medical facilities, such as hospitals.

As Required by Law: We will disclose information about your child when required by law or by court order.

For more information or to report a privacy problem

If you have questions about your child's health or health care services, you should contact your child's health care provider (doctor, hospital, or others).

If you believe your child's privacy rights have been violated:

- You may file a complaint with PeachCare for Kids by calling the Member Inquiry Unit at 1-866-211-0950
- You may file a complaint with the Health and Human Services Office for Civil Rights by writing to:

U.S. Department of Health & Human Services

Office for Civil Rights, Region IV

61 Forsyth Street SW, Suite 3B70

Atlanta, GA 30303-8909

There will be no retaliation for filing a complaint.