

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

# MEDICAID APPLICATION

FOR COUNTY USE ONLY:  
Date Received in County Dept

Check block(s) that apply to you:

- Pregnant Woman  
 Child(ren) Only – RSM  
 Families w/Children – LIM

PLEASE NOTE: A Face to Face interview is not required for Medicaid applications. Please answer all questions as completely and accurately as possible. If you cannot understand or complete this application, please notify DFCS staff and assistance will be provided free of charge.

Your Name: (Please Print) FIRST NAME		M.I.	Last Name:		Today's Date:	
Mailing Address:				City:	State:	Zip Code:
Residence Address (if different from Mailing Address):				Phone Number(s):	E-mail Address:	

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

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

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

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

Is anyone in the household pregnant?  Yes  No If yes, who is pregnant?

Due Date:

Please attach verification of pregnancy if available.

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

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

Company Name:

Policy Number:

**INCOME, RESOURCES and DAYCARE**

List all income received by persons on page 1 of this application. Be sure to show the amount before deductions. Attach an extra sheet if necessary. We will decide, based on the type of Medicaid, whose income must be counted and whose may be excluded. **If you are applying for Children Only or Pregnant Woman Medicaid, you do not have to complete the Resources/Vehicles sections below.**

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

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

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

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

Child's Name	Absent Parent's Name (Mother/Father)	Do they have Medical Coverage on the Child? Yes/No	If Yes to Medical Coverage, please list name of insurance company & group number

I certify that the information I have provided on this application is true and correct to the best of my knowledge. I understand that this information may need to be verified to determine eligibility. I understand wage and salary information supplied by the Georgia Department of Labor may be obtained to verify and determine eligibility for Medicaid. I agree to assign to the state all rights to medical support and third party support payments (hospital and medical benefits).

I understand that I must report changes in my income and circumstances within ten (10) days of becoming aware of the change.

Signature of Self, Parent or Guardian (Required): \_\_\_\_\_ Date: \_\_\_\_\_

**DECLARATION OF CITIZENSHIP/ALIEN STATUS**

I understand that the Ga. Division of Family and Children Services may require verification from the United States Department of Homeland Security (DHS) of my/my children's citizenship or alien status when seeking benefits. Information received from DHS may affect my/my children's eligibility.

Please fill out and sign **ONE or BOTH** of the following statements as it pertains to the status of each person seeking benefits.

**CHILDREN SEEKING BENEFITS**

Name	Place of Birth (city,state,country)	U.S. Citizen (Check whichever applies)	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

I, \_\_\_\_\_ (PRINT NAME) attest to the identity of the child/children listed above and certify under penalty of perjury, that the information written and checked above is true.

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)

**ADULT(S) SEEKING BENEFITS**

Name	Place of Birth (city,state,country)	U.S. Citizen (Check whichever applies)	Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

I, \_\_\_\_\_ (PRINT NAME) attest to the identity of the child/children listed above and certify under penalty of perjury, that the information written and checked above is true.

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN)

\_\_\_\_\_  
(DATE)