109 Big A Rd. • Toccoa, GA 30557
Phone: 1 (706) 886-0940
Fax: 1 (706) 886-0941

PATIENT REGISTRATION APPLICATION

2024

Open Arms is a non-profit charitable clinic open on Tuesdays, Wednesdays, and Thursdays by appointment **only**. We are **not** an emergency care facility. Services are provided for **Stephens County** residents only. All patients must exist at or below 125% of the Federal Poverty Level.

To Apply

1. **Provide all documentation listed on page 2 of this application**. Complete and sign this Patient Application on ***ALL*** pages. If you have any questions, or need assistance, please call 706-886-0940 on Tuesdays from 2-5 PM -*or*- on Thursdays from 9:30AM-5PM.
2. You will need to complete the above process and be approved before you will be given an appointment to see a medical provider or any medication(s).

YOUR APPLICATION WILL NOT BE ACCEPTED, IF YOU DO NOT PROVIDE ALL APPLICABLE DOCUMENTS LISTED ON PAGE 2.

If you qualify, labs will be ordered, and an appointment will be made with the physician for the next available opening. Medication will be given, if ordered, at that time.

Open Arms Clinic Provides the Following Services

- ☑ Care for Chronic Medical Conditions
- ☑ Medication
- ☑ Dental Extractions
- ☑ Ophthalmology Services & Glasses
- ☑ Laboratory & Radiology Services
- ☑ Social Services
- ☑ Adult Immunizations
- ☑ Diabetes Supplies
- ☑ Specialty Referrals
- ☑ Educational Programs
- ☑ Durable Medical Equipment

Open Arms Clinic DOES NOT Provide the Following Services

- ☒ Pain Management or Narcotics
- ☒ Mental Health Services
- ☒ Female Exams
- ☒ Physicals
- ☒ Primary Orthopedic Services

FILL OUT/SIGN ALL HIGHTLIGHTED AREAS

☞ *If you miss your appointment without cancelling 24 hours in advance, it will count as a no-show.* ☜

☞ *If you find that you have to cancel your appointment, you can leave a voicemail with us.* ☜

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PATIENT REGISTRATION APPLICATION

2024

QUALIFICATION GUIDELINES

Open Arms is for low-income adult residents of Stephens County who have no access to insurance. Medicaid and Medicare patients do not qualify.

Please bring *ALL* the following documentation with your application. The list below applies to you, your spouse, and all dependents under the age of 18.

*The documents below are **REQUIRED** by our hospitals and pharmaceutical partners in order to receive medication(s), laboratory & radiology services, referrals, etc.*

1. **Income from Government Sources:**
   - Government or Pension checks
   - Food Stamps, Social Security, Disability, Retirement, Child Support, Alimony, or Workers Compensation, dated **2024**
   - Denial letter from Medicaid dated **2024**
     - You ***MUST*** apply for Medicaid, either using the attached application OR online OR in person. You will be given 8 weeks from your date of application to bring us your denial letter. See PG. 9 for complete information.
2. **Income:**
   - Department of Labor (DOL) statement, dated **2024** (complete pg. 6 and take it to the Department of Labor, ***whether you have worked or not***)
3. **Federal Taxes:**
   - If no taxes filed, must complete a 4506T (PG. 18 of this application)
   - 1040 Tax Return for **2023**, *if filed*. **WE WILL NOT ACCEPT W-2s!**
4. **Household Income:**
   - Yourself, your spouse, and/or dependent children/grandchildren, *under the age of 18*, for whom you are legally responsible
5. **Proof of Residency** (***provide one of the three options below***)
   - Utility bill in your name and/or any legal document, in your name, sent to your physical address
   - If someone provides your housing, please see PG. 11 of this application
6. **Proof of Identification**
   - Legal Georgia Driver's License OR Legal Georgia Identification Card
   - If someone provides your housing, also provide a valid ID for that person
   - If you have none of these, please ask to speak to "Sherry" or "Vanessa." We **DO NOT** discriminate on the basis of citizenship, nationality, ethnicity, race, gender, sexual identity, etc.

All of the above must be given to an Open Arms Representative in person. We cannot register you without a complete application and any applicable documents listed above. THERE ARE NO EXCEPTIONS. Please contact Open Arms if you have questions.

YOU MUST WAIT AT THE CLINIC WHILE YOUR APPLICATION IS BEING REVIEWED

This packet is to be distributed by Open Arms Clinic **ONLY**

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PATIENT REGISTRATION APPLICATION

2024

REGISTRATION SHEET

→ PLEASE PRINT ←

NAME: _____ **TODAY'S DATE:** _____

DATE OF BIRTH: _____ **SSN:** _____ **LANGUAGE:** _____

ADDRESS: _____

CITY: _____ **STATE:** GA **ZIP:** _____ **COUNTY:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMAIL ADDRESS: _____

RACE: _____ **SEX:** M • F • Other **MARITAL STATUS:** _____

TOTAL # OF FAMILY MEMBERS (including yourself) LIVING IN YOUR HOUSEHOLD: _____

LAST GRADE COMPLETED: _____ **ARE YOU EMPLOYED?** Y • N

WHERE ARE YOU EMPLOYED? _____

DO YOU HAVE ACCESS TO ANY HEALTHCARE INSURANCE? Y • N

EMERGENCY CONTACT: **(REQUIRED)** _____ **RELATIONSHIP TO YOU:** _____

ADDRESS: _____

PHONE: **(MUST BE DIFFERENT FROM YOUR OWN)** _____ **ALT PHONE:** _____

WHAT IS YOUR PRIMARY REASON FOR SEEKING MEDICAL CARE: _____

_____

BRING A LISTING OF ALL OF YOUR MEDICATIONS TO EVERY APPOINTMENT.
IF YOU HAVE HIGH BLOOD PRESSURE, KEEP A RECORD OF YOUR PRESSURES AND BRING IT TO EVERY APPOINTMENT.
IF YOU HAVE DIABETES, KEEP A RECORD OF YOUR BLOOD SUGARS AND BRING IT TO EVERY APPOINTMENT.

I hereby authorize Open Arms Clinic to render appropriate services requested and treatment as recommended by the medical staff. This request/Authorization shall be considered continuous in nature unless revoked in writing.

I confirm that the above information is true and understand that all information given to Open Arms Clinic will be kept confidential and cannot be released without my consent.

_____ _____
PATIENT SIGNATURE **TODAY'S DATE**

_____ _____
ISSUING OAC STAFF **TODAY'S DATE**

PATIENT CHART #: _____

COPY FOR HOSP.

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PATIENT REGISTRATION APPLICATION

2024

STEPHENS COUNTY HOSPITAL
163 Hospital Drive, Toccoa, Georgia 30577
(706) 282-4200
Application for Free or Reduced Charge Services

PATIENT INFORMATION

Name:_____

Mailing Address:_____

_____

Home Phone:_____ Alt. Phone:_____

When listing the patient's household members below, list ONLY those that live with the patient and that he or she is legally responsible for, their relationship to the patient, and income from each source. State whether this income is weekly, monthly, or annually.

NAME	BIRTH DATE	RELATIONSHIP	WEEKLY INCOME	MONTHLY INCOME	ANNUAL INCOME

If there is income for any member of the household from self-employment, you may give information on the business cost so that we can determine actual income to be counted. Write the details on the back of this sheet.

Signature of Applicant:_____ Today's Date:_____

HOSPITAL STAFF USE (11/00)

NUMBER IN HOUSEHOLD _____ TOTAL INCOME _____ INCOME VERIFIED: YES NO

(Average monthly income for the last year or past three months, whichever is more favorable)

Determination: Eligible for free service _____ Conditional _____ Pending _____

Eligible for discount _____ % Conditional _____ Pending _____

Ineligible _____ Reason _____

Date Notice Mailed _____ Staff Signature _____

☐SCIC ☐ Outpatient Prescription Service ☐ ICTF

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PATIENT REGISTRATION APPLICATION

2024

SELF DECLARATION OF INCOME

Complete only those that apply…

☐ I declare that I have been working and receiving payment in the amount of $_____
every (*circle one*): DAY • WEEK • TWO WEEKS • MONTH

☐ I have no paycheck stubs or other documentation to prove my earning.

☐ I have provided a list of people I have worked for in the past three months for verification.

LIST NAME(S) OF EMPLOYERS, CONTACT NUMBER(S), AND AMOUNT PAID PER MONTH

_____

_____

_____

◈ OR ◈

☐ I declare that I have no employment and do not have any income of any kind

I have provided a list of people who have helped with my living expenses.

LIST NAME(S) AND CONTACT NUMBER(S) OF ANYONE WHO HAS HELPED YOU BY PAYING FOR YOUR RENT, BILLS, GROCERIES, ETC.

NAME	PHONE	WHAT WAS/IS PROVIDED?	AMOUNT PAID

CERTIFICATION OF INFORMATION

☐ I certify that all income information given on this application and/or to the employees of Open Arms Clinic during registration is complete and true to the best of my knowledge

☐ I certify that I am a legal resident of Stephens County, Georgia

☐ I certify that I do NOT have Medicare, Medicaid, or any other medical or prescription insurance, nor am I covered on anyone else's medical or prescription insurance

☐ I understand that if I knowingly give false information concerning residency, income, or medical insurance status to Open Arms Clinic, I will be immediately discharged as a patient and subject to possible legal action.

PATIENT SIGNATURE **TODAY'S DATE**

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PATIENT REGISTRATION APPLICATION

2024

YOU MUST COMPLETE AND TAKE THIS FORM TO THE DOL OFFICE: 37E FOREACRE ST., TOCCOA, GA 30577

Georgia DOL Department of Labor

Disclosure Request Form
Unemployment Insurance Records

DATE:_____

NAME:_____ (include copy of photo ID)

ADDRESS: *109 Big A. Rd, Toccoa, GA 30577*_____

PHONE: 1)_____ 2)_____

I am requesting the following information on records:

- ☐ Separation Notice/Employer Info. On Discharge
- ☐ Claim Determination (i.e. eligibility decision)
- ☑ Wage Inquiry – WG15 (i.e. employer reported wages)
- ☐ Other:_____

I need the information or records for the following reason:

- ☑ To obtain medical services/medical financial assistance
- ☐ To obtain food/housing assistance
- ☐ To have for my own records
- ☐ For prospective employment (job opportunity)
- ☐ For tax preparation
- ☐ Other:_____

Requestor's Signature:_____ Date:_____

Social Security Number (required):_____

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PATIENT REGISTRATION APPLICATION

2024

CODE OF CONDUCT

Open Arms Clinic is staffed primarily by volunteers. Patients and staff are to conduct themselves in a polite, respectful manner at all times.
Failure to do so will result in immediate termination.

↓ PLEASE READ AND INITIAL AFTER EACH STATEMENT ↓

- _____I understand that physician assignments will be made by Open Arms Clinic, and I am not guaranteed to see the same doctor at each visit.
- _____I understand that I cannot seek primary care services at any other physician's office while an active patient at Open Arms Clinic
- _____I agree to be compliant with my medication and healthcare regimen as ordered by my healthcare provider.
- _____I understand that my medications will ONLY be dispensed at OPEN ARMS CLINIC, unless I am told otherwise.
- _____I will NOT contact Maddox Drugs, NGPG (Toccoa Clinic), or any other physician's office to pick up or request a free refill on medications or to get an appointment.
- _____I will NOT be disrespectful and/or disruptive with any Open Arms Clinic personnel and/or other patients, or arrive to any appointment or specialty appointment (such as dental, eye, etc.) under the influence of drugs and/or alcohol.
- _____I understand that it is my responsibility to call and reorder my medications 7-10 days prior to running out.
- _____I will contact Open Arms Clinic for ANY medical information that I need, and I will NEVER contact a doctor/provider at their private office**.**
- _____I understand that if I do not call to cancel (24 hours prior to scheduled appointment) and fail to show up for any appointment (physician, nurse, etc.), **it will be listed as a "no show"**
- _____I understand that if I am terminated, I may appeal in writing. This appeal must be approved before any services can be reinstated.
- _____I understand that I can leave a message on Open Arms Clinic's telephone system, and I have no excuse not to let Open Arms Clinic know if/when I cannot make an appointment.
- _____I will bring in **ALL** of my medications that I am currently taking to **EVERY** appointment.
- _____If I have high blood pressure (Hypertension) and/or Diabetes, I will keep a record of **ALL** my readings and bring it to **EVERY** appointment.
- _____I understand that I **MUST** present my Open Arms Clinic ID card when sent for lab work, x-rays, or any outside specialty appointment. Failure to do so **may result in being billed**.
- _____I will have **ANY and ALL required lab work** completed **prior** to my scheduled appointment. I understand that failure to do so will result in the immediate cancellation of my appointment.
- _____I understand that I must recertify with Open Arms Clinic by providing new, up-to-date financial information once EVERY YEAR that I wish to remain a patient. I understand that this process takes place ONLY between January and March 31st, and that **failure to recertify will result in termination of care until the following year**.
- _____I understand that I am subject to drug and testing at any time, and if I am found to be positive, I must provide a physician's prescription for that drug.
- _____I give my permission for Open Arms Clinic to act on my behalf to obtain free and reduced priced medication, to request medical records, and/or to obtain specialty referrals; this includes, but is not limited to, signatures and phone communications.
- _____I understand that I need to seek emergency room care **ONLY** in the case of life-threatening conditions.
- _____I understand to receive care for non life-threatening conditions when the clinic is closed, I must register with Giving Health (our after hours care provider [PG. 19]). The contact numbers will be on the back of your Open Arms Clinic patient ID card.

I UNDERSTAND THE ABOVE STATEMENTS AND KNOW THAT FAILURE TO COMPLY MAY RESULT IN MY IMMEDIATE DISCHARGE FROM OPEN ARMS CLINIC

PATIENT SIGNATURE **TODAY'S DATE**

(copy of the Code of Conduct to be provided to the patient)
This packet is to be distributed by Open Arms Clinic **ONLY**

COPY FOR PATIENT

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PATIENT REGISTRATION APPLICATION

2024

PATIENT ASSISTANCE PROGRAM AUTHORIZED INDIVIDUAL(S)

I hereby authorize the following personnel of Open Arms Clinic as advocate(s) on my behalf when interacting with Patient Assistance Programs. This includes the ordering and/or reordering of medication(s) via mail and/or phone with Patient Assistance Program representatives.

FIRST NAME	LAST NAME	TITLE
Marie	Mayner	Nurse, LPN
Sherry	Beavers	Executive Director, Open Arms Clinic Nurse, RN

PATIENT SIGNATURE

ATTN: PAP NURSE

Include a copy of this form with every PAP application.

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PATIENT REGISTRATION APPLICATION

2024

MEDICAID DENIAL LETTER AND/OR FOOD STAMPS STATEMENT

In order to become an Open Arms Clinic patient, we need to know that you **DO NOT** qualify for Medicaid benefits; this is to ensure our ability to order medications, obtain labs, x-rays, and referrals for you at no cost.

You can apply in person at one of the following addresses, call the below number, or apply online at **www.gateway.ga.gov**

OR

Fill out the attached Application for Health Coverage at the back of this application; bring it to us, and we will mail it for you

TOCCOA DFCS*
2711 Big A Rd.
Toccoa, GA 30577
Hours: Monday – Friday, 8am-5pm
**opening early 2024*

LAVONIA DFCS
187 Clear Creek Pkwy
Lavonia, GA 30553
1 (706) 356-0251
Hours: Monday – Thursday, 9am-4pm

HOMER DFCS
154 Windmill Farm Rd.
Homer, GA 30547
1 (706) 677-2272
Hours: Tuesdays – Thursdays, 9am-3pm

CLARKESVILLE DFCS
1045 Grant St.
Clarkesville, GA 30523
1 (706) 754-2148
Hours: Monday – Friday, 8am-5pm

GA DFCS CALL CENTER
(to apply over the phone – early morning is the best time to call)
1 (877) 423-4746
Menu Option Choices
1 – "English"
2 – "No fraud"
1 – "Constituent"
2 – "Apply for benefits"
1 – "Verify"

If we do not receive this documentation from you within 4-8 weeks, we will have to suspend services. Bear in mind, it takes 4-6 weeks from the time that you apply for the documents to be mailed out. In the meantime, we need proof that you have applied, such as: a printed copy of the front page of your application, a screenshot of your online application, and/or your case number.

Patient Signature: _____ **Date:** _____

NOTE TO STAFF: PLACE THIS FORM IN THE MEDICAID ACCORDIAN FILE

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PATIENT REGISTRATION APPLICATION

2024

DECLARATION OF MONTHLY INCOME(S)

PATIENT NAME: _____ **D.O.B.:** _____

SPOUSE/PARTNER NAME: _____ **D.O.B.:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** GA **ZIP:** _____

PHONE #: _____ **ALT. PHONE #:** _____

◈ FAMILY INCOME INFORMATION ◈

Please list all family members within household, and their monthly income (if applicable)

	NAME	MONTHLY INCOME
SELF:		
SPOUSE/PARTNER:		
CHILDREN (under 18):		
i.e. social security, disability, child support, etc.		
OTHER DEPENDENTS:		
i.e. live in grandchildren, foster children, etc.		
(the monetary support received for those individuals)		
TOTAL:		

◈ OTHER INCOME ◈

*Please list the below monthly incomes (if applicable) and bring the government document that states the amount, **dated 2024***

	MONTHLY INCOME
ALIMONY/CHILD SUPPORT:	
SOCIAL SECURITY/PENSION:	
PUBLIC ASSIST/FOOD STAMPS:	
UNEMPLOYMENT/WORKERS' COMP:	
OTHER SOURCES (*please specify*)**:**	
TOTAL INCOME:	

◈ MONTHLY EXPENSES ◈

	PAYMENT AMOUNT
RENT OR MORTGAGE (primary or secondary):	
UTILITIES (standard deduction)	
ELECTRIC:	
GAS:	
WATER:	
CAR OR LIFE INSURANCE:	
CHILD CARE/ADULT CARE:	
GOVERNMENT TAX PAYMENTS:	
OTHER:	

The undersigned hereby acknowledges the information in this statement to be true and correct, to the best of my (our) knowledge.

PATIENT SIGNATURE _____ **DATE** _____ **SPOUSE/PARTNER SIGNATURE** _____ **DATE** _____

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PATIENT
REGISTRATION APPLICATION
2024

CERTIFICATION OF STEPHENS COUNTY RESIDENCY & LIVING ARRANGEMENTS

Select and complete the option that reflects your living situation...

PLEASE CHECK YOUR CURRENT LIVING SITUATION:

☐ RENT ☐ OWN ☐ LIVING WITH A FRIEND/RELATIVE ☐ FRIEND/RELATIVE IS PAYING FOR MY HOUSING ☐ HOMELESS

PLEASE COMPLETE AND SIGN OPTION 1 OR 2, DEPENDING ON YOUR SITUATION

1. ☐ I certify, by my signature below, that I provide all housing and living expenses for myself.
   - ☐ **I certify that my living residence is located in STEPHENS COUNTY, GEORGIA**
   - ☐ **I am providing a copy of my Georgia photo ID – reflecting my living address – with this application.**

____
PATIENT SIGNATURE **TODAY'S DATE**

____
REGISTRAR/OAC WITNESS SIGNATURE **TODAY'S DATE**

◈ OR ◈

If someone else is providing housing and living expenses FOR you,
*they **MUST** personally check and sign the option below, and complete the letter on pg. 12*

2. ☐ I certify, by my signature below, that I am providing full or part time housing* for: ______________________
   PATIENT'S NAME

**** IF YOU ARE PROVIDING HOUSING FOR THE APPLICANT: you MUST provide a letter on the following page, stating your name and that you provide housing for the patient.***

☐ **I certify that that this residence is located in STEPHENS COUNTY, GEORGIA**

☐ **I am providing a copy of my Georgia photo ID – reflecting this living residence – with this application**

____
RESIDENTIAL PROVIDER SIGNATURE **TODAY'S DATE**

____
REGISTRAR/OAC WITNESS SIGNATURE **TODAY'S DATE**

<><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><>

NOTARY

(Open Arms Clinic has a Public Notary in the office)

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PATIENT REGISTRATION APPLICATION

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LETTER FROM HOUSING PROVIDER

ANY PERSON PROVING HOUSING **MUST** WRITE A STATEMENT ON THIS PAGE, VERIFYING THAT THEY DO SO AND SIGN AT BOTTOM

Date: _____

	NOTARY
	(Open Arms Clinic will Notarize this document for you)

Signature of housing provider: _____

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PATIENT REGISTRATION APPLICATION

2024

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

NOTICE TO PATIENTS

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practical

OR

To a parent or legal guardian when the patient lacks legal responsibility for his/her care under State Law

This is to notify you that under Federal Law relating to the operation of free clinics, the Federal Tort Claims Acts (FTCA), (See 28 U.S.C. §§1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. §233(a), (o)).

Certain free clinic health care professionals providing health care services to patients at Open Arms Clinic may be covered by the above Federal Law.

I have read and acknowledged the above statement:

PATIENT SIGNATURE **TODAY'S DATE**

PLEASE PRINT NAME

COPY FOR PATIENT

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PATIENT REGISTRATION APPLICATION

2024

HOW/WHEN TO RE-ORDER MEDICATIONS & HOLIDAY CLOSURES NOTICE
PATIENT MUST READ

RE-ORDERING MEDICATION

IT IS YOUR RESPONSIBILITY TO ORDER YOUR MEDICATION(S) BEFORE YOU RUN OUT!

- When you get down to a 10-day supply of your medication(s), you must call us to re-order them. Please have the **NAME** and **DOSE** of your medication(s) ready when you call.
- We only fill medication(s) on Tuesday Evenings. Any medication(s) ordered on a Thursday will not be available until the following Thursday.
- *PLAN FOR HOLIDAY CLOSURES!* Note when we plan to be closed and order your medicine(s) by the Tuesday afternoon before we will be out, to ensure that you have enough of your medication(s) to last you throughout the break.

2024 DATES THAT WE ARE CLOSED

4TH OF JULY WEEK

- We will be closed from June 28th – July 8th
  - *The last day to order medication(s) and receive them on time will be June 25th, BEFORE 6PM*
- We will open again on Tuesday, July 9th at 2:00PM

THANKSGIVING WEEK

- We will be closed from Nov. 22nd – Dec. 2nd
  - *The last day to order medication(s) and receive them on time will be November 19th, BEFORE 6PM*
- We will open again on Tuesday, Dec. 3rd at 2:00PM

CHRISTMAS & NEW YEAR

- We will be closed from Dec. 20th, 2024-Jan. 6th, 2025
  - *The last day to order medication(s) and receive them on time will be December 17th, BEFORE 6PM*
- We will open again on Tuesday, Jan. 7th, 2025 at 2:00PM

☐ *I understand when Open Arms Clinic will be closed and when/how to re-order my medication(s).*

PATIENT SIGNATURE **TODAY'S DATE**

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PATIENT REGISTRATION APPLICATION

2024

MEDICAL HISTORY (PG.1)

Name:_____ DOB:_____ Occupation:_____

(please circle **Y**es or **N**o)

ALL PATIENTS

Current Medications (name and dose)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

VACCINES (if applicable)

- Influenza _____ **Y** **N** Last received: _____
- Shingles _____ **Y** **N** Last received: _____
- Pneumonia _____ **Y** **N** Last received: _____
- COVID-19* _____ **Y** **N**

BRAND: ☐ Moderna ☐ Pfizer ☐ J&J

Total number of doses: _____

Date of last dose: _____

_____

When did you last see an eye doctor? _____

When did you last get a pair of prescription glasses? _____

Are you currently having any dental pain/problems? **Y** **N**

Would you like to schedule an extraction? **Y** **N**

NEW PATIENTS ONLY:

Allergies

- Aspirin _____ **Y** **N**
- Iodine _____ **Y** **N**
- -mycins _____ **Y** **N**
- Penicillin _____ **Y** **N**
- Sulfa _____ **Y** **N**
- Other _____

_____

_____

Hospitalizations (most recent dates and reasons)

1. _____
2. _____
3. _____
4. _____
5. _____

Surgeries

- Appendix _____ **Y** **N**
- Ortho _____ **Y** **N**
- Gallbladder _____ **Y** **N**
- Hernia _____ **Y** **N**
- GYN _____ **Y** **N**
- Tonsils _____ **Y** **N**
- OTHER: _____

_____

Lifestyle

- Smoke _____ **Y** **N**
  ☐ Current ☐ Former Packs a day: _____
- Alcohol _____ **Y** **N**
  ☐ Frequent ☐ Casual ☐ Limited
- Drugs _____ **Y** **N**
  ☐ Current ☐ Former

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PATIENT REGISTRATION APPLICATION

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Medical History (PG. 2)

Family History *– Any history of diabetes, cancer, high blood pressure, stroke, allergies, blood disease, etc.? If yes, in whom?*

_____

_____

FATHER

Deceased _____ **Y** **N** If **Y**, age at time of death: _____

Known Medical Problems: _____

MOTHER

Deceased _____ **Y** **N** If **Y**, age at time of death: _____

Known Medical Problems: _____

Past Medical History

- Arthritis _____ **Y** **N**
- Cancer _____ **Y** **N**
- Chicken Pox _____ **Y** **N**
- COPD _____ **Y** **N**
- COVID-19 _____ **Y** **N**
- Diabetes _____ **Y** **N**
- Epilepsy/Seizures _____ **Y** **N**
- Heart Trouble _____ **Y** **N**
- Hepatitis B or C _____ **Y** **N**
- High Blood Pressure _____ **Y** **N**
- Migraines _____ **Y** **N**
- Pneumonia _____ **Y** **N**
- Rectal Bleeding _____ **Y** **N**
- Stroke _____ **Y** **N**
- TB _____ **Y** **N**
- Venereal Disease (STD) _____ **Y** **N**
- Other Medical Problems: _____

FEMALE

- Menopause _____ **Y** **N**
- Date of last period: _____
- Date of last mammogram: _____

Current Complaints

- Abdominal cramps _____ **Y** **N**
- Anxiety _____ **Y** **N**
- Arthritis _____ **Y** **N**
- Backaches _____ **Y** **N**
- Bladder infection _____ **Y** **N**
- Bleeding or sore gums _____ **Y** **N**
- Blood in bowel movement _____ **Y** **N**
- Blood in urine _____ **Y** **N**
- Blurred vision _____ **Y** **N**
- Breathless after any exertion _____ **Y** **N**
- Brittle nails _____ **Y** **N**
- Change in bowel movement _____ **Y** **N**
- Change in hair texture _____ **Y** **N**
- Chest pain _____ **Y** **N**
- Chronic or frequent coughs _____ **Y** **N**
- Constipation _____ **Y** **N**
- Cough upon lying down _____ **Y** **N**
- Coughing up blood _____ **Y** **N**
- Decrease in hearing _____ **Y** **N**
- Depression _____ **Y** **N**
- Diarrhea _____ **Y** **N**
- Difficulty exercising _____ **Y** **N**

109 Big A Rd. • Toccoa, GA 30557
Phone: 1 (706) 886-0940
Fax: 1 (706) 886-0941

PATIENT REGISTRATION APPLICATION

2024

Medical History (PG.3)

Current Complaints (continued)

- Difficulty sleeping Y N
- Difficulty swallowing Y N
- Discharge from ear Y N
- Dizziness Y N
- Double vision Y N
- Earaches Y N
- Easy bruising Y N
- Enlarged glands Y N
- Eye injury Y N
- Fainting spells Y N
- Fatigue Y N
- Fluttering or palpitations of heart Y N
- Frequent or severe headaches Y N
- Frequently confused Y N
- Hair loss Y N
- Hay fever Y N
- Heartburn Y N
- High blood pressure Y N
- Hot flashes Y N
- Joint pain Y N
- Kidney stones Y N
- Leg cramps at night or when walking Y N
- Loss of or strange taste(s) Y N
- Loss of sensation in hands or feet Y N
- Muscle spasm(s) Y N
- Nausea or vomiting Y N
- Night sweats Y N
- Pain behind eyes Y N
- Pain in arm(s) Y N
- Pain with bowel movement Y N
- Painful urination Y N
- Penis discharge Y N
- Persistent body orders Y N
- Persistent hoarseness Y N
- Prostate trouble Y N
- Purple lips or fingers Y N
- Recurrent colds Y N
- Recurrent mouth sores Y N
- Recurrent sore throat Y N
- Red or warm joint(s) Y N
- Ringing in ears Y N
- Sinus trouble(s) Y N
- Skin rash(es) Y N
- Spots before eyes Y N
- Swelling of hands or feet Y N
- Tar-like, black stool(s) Y N
- Tingling of hands or feet Y N
- Tremors Y N
- Unconscious spell or convulsions Y N
- Urine loss with cough or sneeze Y N
- Varicose veins Y N
- Vision change Y N
- Vomiting blood Y N
- Wake to urinate Y N
- Waking up short of breath Y N
- Weight gain/weight loss Y N
- Other:_____

Form **4506-T**
(June 2023)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 transcript.

12 / 31 / 2023	/ /	/ /	/ /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☑ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____
Signature (see instructions) Date

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

OPEN ARMS CLINIC
109 BIG A RD. • TOCCOA, GA 30577
PHONE: ***1 (706) 886-0940*** **• FAX:** ***1 (706) 886-0941*** **• EMAIL:** ***OPENARMSGA@GMAIL.COM***

GIVING HEALTH

FREE AFTER-HOURS TELEHEALTH SERVICES
REGISTRATION AGREEMENT

OPEN ARMS CLINIC HAS PARTNERED WITH GIVING HEALTH TO PROVIDE OUR PATIENTS WITH FREE AFTER-HOURS TELEMEDICINE SERVICES. THIS PARTNERSHIP ALLOWS YOU, THE PATIENT, TO REACH A MEDICAL PROFESSIONAL WHEN OPEN ARMS CLINIC IS CLOSED, SO THAT YOU DO NOT HAVE TO RESORT TO THE EMERGENCY ROOM, UNLESS YOU FEEL THAT YOU ARE IN A LIFE-THREATENING EMERGENCY. THIS SERVICE WILL INCLUDE PRESCRIPTION(S) FORWARDED TO MADDOX DRUGS (1330 BIG A RD.) AT NO COST TO YOU, IF DEEMED NECESSARY.

☐ **I AGREE** TO HAVE OPEN ARMS CLINIC REGISTER ME FOR THE GIVING HEALTH SERVICE, GIVING ME ACCESS TO FREE MEDICAL CARE WHEN OPEN ARMS CLINIC IS CLOSED.

☐ **I DO NOT WANT** OPEN ARMS CLINIC TO REGISTER ME FOR THE GIVING HEALTH SERVICE; I UNDERSTAND THAT I WILL BE UNABLE TO ACCESS AFTER-HOURS HEALTHCARE, OTHER THAN GOING TO THE EMERGENCY ROOM, FOR WHICH I MAY OR MAY NOT BE BILLED.

PATIENT NAME/SIGNATURE: _____ **DATE:** _____

OFFICE INSTRUCTIONS

FORWARD FORM TO VANESSA

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Application for Health Coverage & Help Paying Costs

Form Approved
OMB No. 0938-1191

THINGS TO

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from **Medical Assistance**.

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Attachment C.

Apply faster online

Apply faster online at gateway.ga.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Send your complete, signed application to the address on page 8.
If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit gateway.ga.gov or call **1-877-423-4746**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** gateway.ga.gov
- **Phone:** Call our Help Center at **1-877-423-4746.**
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-877-423-4746** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-877-423-4746.**

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

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

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

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) –

15. Other phone number ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

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

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov.** TTY users should call 1-800-255-0135.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No If yes, what is the expected due date __/__/__; and how many babies are expected? _____

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No

15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other ___

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

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number
( ) –

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

25. Average hours worked each WEEK

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ Start working more hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

28. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ How often?

☐ Pensions $ How often?

☐ Social Security $ How often?

☐ Retirement accounts $ How often?

☐ Alimony received $ How often?

☐ Net farming/fishing $ How often?

☐ Net rental/royalty $ How often?

☐ Other income $ How often?

Type: _____

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

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

30. **YEARLY INCOME:** **Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.**

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

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

STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

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

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐Male ☐Female

5. Social Security number (SSN) _____ - _____ - _____
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐Yes ☐No
If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐Yes ☐No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐Yes ☐No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐Yes ☐No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐Yes ☐No If yes, what is the expected due date __/__/__ ; and how many babies are expected? _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐Yes ☐No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐Yes ☐No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type
b. Document ID number _____
c. Has PERSON 2 lived in the U.S. since 1996? ☐Yes ☐No
d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐Yes ☐No

13. Does PERSON 2 want help paying for medical bills from the last 3 months?
☐Yes ☐No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child?
☐Yes ☐No

15. Was PERSON 2 in foster care at age 18 or older?
☐Yes ☐No

Please answer the following questions if PERSON 2 is under the age of 19.

16. Did PERSON 2 have health insurance and lose it within the past 2 months? ☐Yes ☐No
a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐Yes ☐No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐Mexican ☐Mexican American ☐Chicano/a ☐Puerto Rican ☐Cuban ☐Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐White
☐Black or African American
☐American Indian or Alaska Native
☐Asian Indian
☐Chinese
☐Filipino
☐Japanese
☐Korean
☐Vietnamese
☐Other Asian
☐Native Hawaiian
☐Guamanian or Chamorro
☐Samoan
☐Other Pacific Islander
☐Other ___

Now, tell us about any income from PERSON 2 on the back.

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

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ Start working more hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

30. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ How often?

☐ Pensions $ How often?

☐ Social Security $ How often?

☐ Retirement accounts $ How often?

☐ Alimony received $ How often?

☐ Net farming/fishing $ How often?

☐ Net rental/royalty $ How often?

☐ Other income $ How often?

Type: _____

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

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

32. **YEARLY INCOME:** **Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

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

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Attachment B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medical Assistance_____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

☐ VA Health Care Programs _____

☐ Peace Corps _____

☐ Employer insurance _____

☐ Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐Yes ☐No

Is this a retiree health plan? ☐Yes ☐No

☐Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐Yes ☐No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to complete and include Attachment A.

☐ **NO. If no, continue to Step 5.**

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must report any changes within 10 calendar days of the date of which the change occurs. I can visit **gateway.ga.gov** or call **1-877-423-4746** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by calling the Georgia Department of Community Health, Office of Inspector General (OIG), Program Integrity Section at 404-463-7590 or toll free at 1-800-533-0686.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, Department of Labor (DOL), TALX (work number), the Department of Homeland Security and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Insurance Agencies, DFCS and the FFM to use income data, including information from tax returns. The Health Insurance Agencies, DFCS and the FFM will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medical Assistance

- I am giving to the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medical Assistance agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Agencies, DFCS and the FFM has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Agencies, DFCS or the FFM that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Division of Family & Children Services (DFCS) at **1-877-423-4746**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Attachment C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your signed application to the address below:

Division of Family and Children Services
Customer Contact Center
P.O. Box 4190
Albany, GA 31706

If you want to register to vote, you can complete a voter registration form at **www.sos.ga.gov**.