PeachCare for Kids™

APPLICATION SIGNATURE FORM

In order to complete the signature requirement of your application, please fill in the spaces below, sign, date and send this form to us.

Child's Full Name	Child's Date of Birth	Child's Place of Birth (city, state, county)

Please list the names of the children for whom you want health benefits.

- I am signing this form under penalty of perjury which means I have provided true answers to all the questions on my application 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 **PeachCare. org** or call 877 GA PEACH (427-3224) 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 is not 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 800-533-0686.
- I confirm that no one applying for health insurance on the application is incarcerated (detained or jailed). If they are, _____ 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 will 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, PeachCare for Kids and the Health Insurance Marketplace to use income data, including information from tax returns. The Health Insurance Agencies, DFCS, PeachCare for Kids, and the Health Insurance Marketplace 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 the application is eligible for Medicaid
I am giving to the Medicaid 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 Medicaid agency rights to pursue and get medical support from a spouse or parent.

Does any child on my 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.

(Please certify one of the following)

☐ If I am applying for health benefits for myself, I certify under penalty of perjury that I am a U.S. Citizen and/or lawfully present in the United States. If I am a parent or legal guardian, I certify that the applicant(s) is a U.S. Citizen and/or lawfully present in the United States.

☐ If I am applying for someone else, I certify to the best of my knowledge and belief that the person(s) for whom I am applying for health benefits is/are U.S. Citizen(s) or are lawfully present in the United States. I further certify that all of the information provided on the application is true and correct to the best of my knowledge.

My right to appeal
If I think the Health Insurance Agencies, Department of Family and Children Services (DFCS), PeachCare for Kids or the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance agencies, DFCS, PeachCare for Kids or the Health Insurance Marketplace 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 **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 form. The person who filled out Step 1 of the application should sign this form.

Signature	Date (mm/dd/yyyy)

ASSISTANCE WITH COMPLETING THIS FORM

You can choose an authorized representative.

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

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address:		3. Apartment or suite number:
4. City	5. State	6. ZIP code
7. Phone Number **( ) --**		
8. Organization name		9. ID number (if applicable):

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

10. Your signature	11. Date (mm/dd/yyyy)