Georgia Department of Human Services
SNAP/MEDICAID/TANF Renewal Form

If you need help reading or completing this document or need help communicating with us, ask us or call (877) 423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).

For Office Use only: Date Received _____ Client ID # _____ Date Initiated: _____ Programs Initiated: ☐ TANF ☐ SNAP ☐ Medicaid

If you are reapplying for SNAP or renewing your TANF or Medicaid benefits, you can file this renewal/application form with only your name, address, and signature. **However, it will help us to process your application, recertification/renewal more quickly if you complete the entire form and provide verification of information, if it is requested.** You may use this form to file a joint renewal/application for the SNAP/Medicaid and/or TANF program or for SNAP only. Your SNAP renewal will not be terminated solely on the basis that your renewal/application for another program has been denied/terminated. We will make a separate eligibility determination for your SNAP renewal.

Please PRINT the name and address of the person who is reapplying for benefits in the space below:

Client Name:	Date of Birth:	Social Security Number: (Optional for Non-Applicants*)
Are you homeless? Yes ____ No ____		*See Citizenship Immigration Status & Social Security Numbers below.
Street Address:		
Mailing Address:		
Main Phone Number:	Other Contact Number:	
Electronic Communication: Email: Yes ___ or No ___ (optional) Texting: Yes ___ or No ___ (optional)	Email Address: (optional)	
What is your Preferred Language?	If an interview is required, will you need an interpreter?	Yes___ or No _____

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):

Do you have a disability that will require a Reasonable Modification or Communication Assistance? Yes No___
(If yes, please describe the reasonable modification or Communication Assistance that you are requesting):

Sign Language interpreter____; TTY____; Large Print___; Electronic communication (email)___; Braille___;
Video Relay____; Cued Speech Interpreter____; Oral Interpreter____; Tactile Interpreter____; Telephone call reminder of program deadlines___; Telephonic signature (if applicable)__; Face-to-face interview (home visit)__;
Other:_____

Do you need this Reasonable Modification or Communication Assistance one-time__or ongoing____? If possible, briefly explain when and how long you need this modification or assistance?