Georgia Department of Human Services
FOOD STAMP/MEDICAID/TANF Renewal Form

If you need help filling out this renewal/application form or need assistance communicating with us, ask us or call 1-877-423-4746. If you are deaf or hard of hearing, please call GA Relay at 1-800-255-0135. Our services are free.

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

Does the applicant or person renewing/applying on behalf of the applicant need assistance when communicating with us? If so check all that apply.

( ) TTY ( ) Braille ( ) Large Print ( ) E-mail ( ) Video Relay) ( ) Sign Language Interpreter _____

( ) Foreign Language Interpreter (specify language) _____ ( ) Other _____

If you are reapplying for Food Stamps 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 and/or 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 Food Stamp/Medicaid and/or TANF program or for the Food Stamp Program (FS) only. Your Food Stamp 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 Food Stamp 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:
Street Address:		
Mailing Address:		
Main Phone Number:	Other Contact Number:	E-mail Address (optional)

I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying/renewing benefits for is/are U.S. citizen(s) or are lawfully present in the United States. I further certify that all of the information provided on this form is true and correct to the best of my knowledge. I understand and agree that DHS and authorized Federal Agencies may verify the information I give on this form. Information may be obtained from past or present employers. I will report any change in my situation according to Food Stamp/Medicaid and/or TANF program requirements. If any information is incorrect, benefits may be reduced or denied and I may be subject to criminal prosecution or disqualified from DHS programs for knowingly providing incorrect information. I understand that I can be prosecuted if I provide false information or hide information. I understand that if I fail to tell DHS about some of my expenses at my application or renewal interview that DHS will not budget that expense in calculating the amount of my food stamp benefits.

Signature Date

Witness Signature if signed by 'X' Date