Georgia Access Consumer Paper Application

Consumers who wish to apply for health coverage through Georgia Access by mail should use this paper application. Consumers must complete this application either by filling out the PDF electronically and then printing it, or by printing it and writing in their responses. Completed and signed paper applications should be mailed to the address below. Consumers can also apply online with a Georgia Access certified web broker, Georgia Access insurance company, Georgia Access certified agent, or through the Georgia Access consumer portal.

ATTN: Consumer Paper Application
Georgia Access Contact Center
PO Box 12264
Birmingham, AL 35202

If you have additional household members or information, make copies as needed for each section and attach.

STEP 1: CONTACT INFORMATION

*Provide information for the **Primary Point of Contact** for the application. The **Primary Point of Contact** for your application must be a member of your household aged 18 or older.*

Primary Point of Contact – Contact Information			
1. First Name	**2. Middle Name** *(if applicable)*	**3. Last Name**	**4. Suffix**
5. Date of Birth *(mm/dd/yyyy)*		**6. Email**	
7. Home Phone Number		**8. Mobile Phone Number** *(if applicable)* ☐ Send me important alerts to this phone number. Standard message rates may apply.	
9. Home Address *(leave 9-14 blank if you do not have one)*		**10. Home Address 2** *(if applicable)*	
11. City	**12. County**	**13. State**	**14. Zip Code**
15. Mailing Address *(if different than home address, complete 15-20)*		**16. Mailing Address 2** *(if applicable)*	
17. City	**18. County**	**19. State**	**20. Zip Code**

Primary Point of Contact – Contact Information	
21. Preferred Method of Communication *(select one)*	☐ Electronic (i.e., notices sent to secure inbox or via email) ☐ Paper (i.e., notices sent to mailing address)
22. Preferred Written Language	**23. Preferred Spoken Language**

STEP 2: INFORMATION FOR PRIMARY POINT OF CONTACT

*Complete Step 2 by providing the following information for the **Primary Point of Contact** listed in Step 1.*

*You do not need to provide immigration status or a Social Security Number for the **Primary Point of Contact** if they do not need health coverage. We will keep all the information you provide private and secure, as required by law. We will use personal information only to check if you are eligible for health coverage.*

Primary Point of Contact – Additional Information		
1. Marital Status ☐ Married ☐ Not Married	**2. Sex** ☐ Female ☐ Male	
3. Social Security Number (SSN) Please provide your SSN if you have one. If no SSN is provided, you will be required to provide additional documentation at the end of the application. Providing your SSN can help verify your eligibility to enroll in coverage. If you do not have an SSN and want to apply, please visit www.ssa.gov/ssnumber. If you do not have an SSN, please leave this blank and see the section below to provide further information. _____-_____-_____ ☐ I do not need coverage, so I am not providing my SSN.		
4. Do you plan to file a federal income tax return for 2025? *(You can still apply for coverage even if you do not file a federal income tax return)*	☐ **Yes**	☐ **No** *If no, skip to question 7.*
5. If you plan to file a federal income tax return next year, will you file jointly with a spouse? *If yes, write the name of your spouse below:*	☐ **Yes**	☐ **No**
Name:		
6. If you plan to file a federal income tax return next year, will you claim any dependents on your tax return? *If yes, list name(s) of dependents below:*	☐ **Yes**	☐ **No**
Name:		
Name:		
Name:		
Name:		

Primary Point of Contact – Additional Information		
7. Will you be claimed as a dependent on someone's tax return? *If yes, list the name of the tax filer below:*	☐ **Yes**	☐ **No**
Name:		
8. Are you pregnant? *If yes, please list how many children are expected during this pregnancy and your estimated due date below:*	☐ **Yes**	☐ **No**
Number of children expected during pregnancy:		
Estimated due date *(mm/dd/yyyy)*:		
9. Were you pregnant in the past 12 months?	☐ **Yes**	☐ **No**
10. If you are applying for health insurance, are you currently incarcerated *(detained or jailed)*?	☐ **Yes**	☐ **No** *If no, skip to question 12.*
11. Are you currently facing disposition of charges?	☐ **Yes**	☐ **No**
12. Do you need health coverage?	☐ **Yes**	☐ **No** *If no, skip to "Current Job & Income Information" below.*
13. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.), have a special health care need, or live in a medical facility or nursing home?	☐ **Yes**	☐ **No**
14. Are you a U.S. citizen or U.S. national?	☐ **Yes** *If yes, skip to question 20.*	☐ **No**

Primary Point of Contact – Additional Information		
15. Are you a naturalized citizen or derived citizen? *If yes, please list your Alien Number and Certificate Number below:*	☐ **Yes** *If yes, please list your Alien Number and Certificate Number, then skip to question 20.*	☐ **No**
Alien Number:		
Certificate Number:		
16. If you are not a U.S. citizen or national, do you have an eligible immigration status? *If yes, complete the section below:*	☐ **Yes**	☐ **No** *If no, skip to question 20.*
Immigration Document Type:		
ID Number:		
Status Type *(optional)*:		
Name *(as shown on your immigration document)*:		
Alien or I-94 Number:		
Card or Passport Number:		
SEVIS ID or Expiration Date *(optional)*:		
Other *(category code or country of issuance)*:		

Primary Point of Contact – Additional Information

17. Do you also have any of these documents? *(select all that apply)*

- ☐ Certification from U.S. Department of Health and Human Services (HHS)
- ☐ Certificate from the Office of Refugee Resettlement
- ☐ Office of Refugee Resettlement Eligibility Letter (if under 18)
- ☐ Cuban/Haitian Entrant
- ☐ Resident of American Samoa
- ☐ Battered spouse, child, or parent under *Violence Against Women Act*
- ☐ Document indicating member of federally recognized Indian tribe or American Indian born in Canada
- ☐ Document indicating withholding of removal
- ☐ None of these

Primary Point of Contact – Additional Information		
18. Have you had primary residence in the U.S. since 1996?	☐ **Yes** *If yes, skip to question 20.*	☐ **No**
19. Have you had your current immigration status for the last 5 years?	☐ **Yes**	☐ **No**
20. Are you, or your spouse or parent, an honorably discharged veteran or an active-duty member of the U.S. military? *(optional)*	☐ **Yes**	☐ **No**
21. Do you want help paying for medical bills from the last 3 months?	☐ **Yes**	☐ **No**
22. Do you live with at least one child under the age of 19, and are you the primary person taking care of this child / these children? *If yes, list the names of the children and your relationship to them below:*	☐ **Yes**	☐ **No**
Name:	**Relationship:**	
Name:	**Relationship:**	
Name:	**Relationship:**	
Name:	**Relationship:**	
23. Are you a full-time student?	☐ **Yes**	☐ **No**
24. Were you in foster care at age 18 or older? *If yes, please list the age you left foster care below*:	☐ **Yes**	☐ **No** *If no, skip to question 26.*
Age:		
25. During your time in foster care, did you receive Medicaid from a U.S. State? *If yes, please list which State below:*	☐ **Yes**	☐ **No**
State:		
26. Are you an American Indian or Alaska Native?	☐ **Yes** *If yes, complete Appendix B.*	☐ **No**

Primary Point of Contact – Additional Information		
27. Are you of Hispanic/Latino ethnicity? *(optional)*	☐ **Yes**	☐ **No**
28. What is your race? *(optional; select all that apply)*	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ Other: Asian ☐ Other: Pacific Islander ☐ Other: _____	

Help Paying for Coverage

*Answer the question below to indicate whether this **Primary Point of Contact** wants help paying for coverage.*

- *If "Yes" is selected, this **Primary Point of Contact** will be assessed for eligibility for subsidies that could lower their cost of health insurance and for Georgia Medicaid and/or PeachCare for Kids®.*
- *If "No" is selected, skip the "Current Job & Income Information" section below for this **Primary Point of Contact**. This **Primary Point of Contact** will not be considered for subsidies or for Georgia Medicaid and/or PeachCare for Kids® and will be applying for full-cost insurance.*

Do you want to be considered for financial assistance to help pay for health coverage?	☐ **Yes**	☐ **No** *If no, skip to Step 3.*

Current Job & Income Information

Provide information about any income you receive. Skip this section if you selected "No" to the question above about being considered for financial assistance to help pay for health coverage.

Employment Status		
☐ **Yes, Employed** *Continue with "Current Job 1."*	☐ **Yes, Self-Employed** *Skip to "Self-Employed" section, below "Current Job 2."*	☐ **Not Employed** *Skip to "Other Income" section, below "Self-Employed."*

Current Job 1			
1. Employer Name			
2. Employer Address			
3. City	**4. State**	**5. Zip Code**	**6. Employer Phone Number**

7. Wages/Tips *(before taxes)*	**8. Frequency of Pay**	**9. Average hours worked each week**
$	☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a Month ☐ Yearly	

Current Job 2 *(if applicable)*

If you have more than two current jobs, please attach another sheet of paper containing the information requested below for each additional job.

1. Employer Name			
2. Employer Address			
3. City	**4. State**	**5. Zip Code**	**6. Employer Phone Number**
7. Wages/Tips *(before taxes)* $	***8.*** **Frequency of Pay** ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a Month ☐ Yearly	**9. Average hours worked each week**	

Self-Employed

1. Type of Work	**2. How much net income *(profits once business expenses are paid)* will you get from this self-employment this month?** $

Other Income *Select all that apply and give the amount and how often you receive the income. You do not need to report income from child support, veteran's payments, or Supplemental Security Income (SSI).*		
☐ **Unemployment**	**Amount** $	**Frequency**
☐ **Alimony Received**	**Amount** $	**Frequency**
☐ **Pension**	**Amount** $	**Frequency**
☐ **Net Farming/Fishing**	**Amount** $	**Frequency**
☐ **Social Security**	**Amount** $	**Frequency**
☐ **Net Rental/Royalty**	**Amount** $	**Frequency**
☐ **Retirement Accounts**	**Amount** $	**Frequency**
☐ **Scholarships**	**Amount** $	**Frequency**
☐ **Investment**	**Amount** $	**Frequency**
☐ **Capital Gains**	**Amount** $	**Frequency**
☐ **Other Income** *(please identify)*:	**Amount** $	**Frequency**

Deductions *Select all that apply. Please provide the amount and how often you pay the deduction. Note: If you pay for certain payments that can be deducted on a federal income tax return, including the costs in this application, it may result in a lower cost of health coverage.*		
☐ **Alimony Paid** (***Note:*** *Only include this deduction if the divorce was finalized before 1/1/2019.)*	**Amount** $	**Frequency**
☐ **Student Loan Interest**	**Amount** $	**Frequency**
☐ **Other Deductions** *(please identify)*:	**Amount** $	**Frequency**
Expected Income *Complete this question if your income changes during the year. For example, if you only work at a job for part of the year or receive a benefit only for certain months. If you do not expect changes to your monthly income, skip to Step 3.*		
Your Total Income this Year $	**Your Estimated Total Income Next Year** $	**Is your income hard to predict?** ☐ **Yes** ☐ **No**

STEP 3: INFORMATION FOR OTHER HOUSEHOLD MEMBERS

*Complete Step 3 for each **Household Member** including your spouse/partner, any dependents who live with you, and/or anyone on your federal income tax return if you file one. If you do not file a tax return, remember to still add the people in your household. See the "Georgia Access Consumer Paper Application Information Sheet" for more information about who to include.*

*If you have more than one additional **Household Member**, make additional copies of Step 3, complete one for each additional **Household Member**, and attach.*

*You do not need to provide immigration status or SSN for a **Household Member** who is not applying for health coverage. We will keep all the information you provide private and secure, as required by law. We will use personal information only to check if you are eligible for health coverage.*

Household Member Information			
1. First Name	**2. Middle Name** *(if applicable)*	**3. Last Name**	**4. Suffix**
5. Date of Birth *(mm/dd/yyyy)*		**6. Relationship to Primary Point of Contact**	
7. Marital Status ☐ Married ☐ Not Married		**8. Sex** ☐ Female ☐ Male	
9. Does this Household Member live at the same address as the Primary Point of Contact?		☐ **Yes** *If yes, skip to question 16.*	☐ **No**
10. Home Address *(leave 10-15 blank if you do not have one)*		**11. Home Address 2** (*if applicable*)	
12. City	**13. County**	**14. State**	**15. Zip Code**
16. Mailing Address *(if different than home address, complete 16-21)*		**17. Mailing Address 2** (*if applicable*)	
18. City	**19. County**	**20. State**	**21. Zip Code**
22. Preferred Written Language		**23. Preferred Spoken Language**	

Household Member Information

24. Social Security Number (SSN)

Please provide the SSN for this Household Member if they have one. If no SSN is provided, they will be required to provide additional documentation at the end of the application. Providing the SSN can help verify their eligibility to enroll in coverage. If this Household Member does not have an SSN and wants to apply, please visit www.ssa.gov/ssnumber. If you do not have an SSN, please leave this blank and see the section below to provide further information.

_____-_____-_____

☐ They do not need coverage, so I am not providing their SSN.

25. Does this Household Member plan to file a federal income tax return for 2025? *(They can still apply for coverage even if they do not file a federal income tax return)*	☐ **Yes**	☐ **No** *If no, skip to question 28.*
26. If this Household Member plans to file a federal income tax return next year, will they file jointly with a spouse? *If yes, write the name of their spouse below:*	☐ **Yes**	☐ **No**
Name:		
27. If this Household Member plans to file a federal income tax return next year, will they claim any dependents on their tax return? *If yes, list name(s) of dependents below:*	☐ **Yes**	☐ **No**
Name:		
Name:		
Name:		
Name:		
28. Will this Household Member be claimed as a dependent on someone's tax return? *If yes, list the name of the tax filer below:*	☐ **Yes**	☐ **No**
Name:		

Household Member Information		
29. Is this Household Member pregnant? *If yes, please list how many children are expected during this pregnancy and the estimated due date below:*	☐ **Yes**	☐ **No**
Number of children expected during pregnancy:		
Expected due date (mm/dd/yyyy)**:**		
30. Was this household member pregnant in the past 12 months?	☐ **Yes**	☐ **No**
31. If this Household Member is applying for health insurance, are they currently incarcerated *(detained or jailed)*?	☐ **Yes**	☐ **No** *If no, skip to question 33.*
32. Are they currently facing disposition of charges?	☐ **Yes**	☐ **No**
33. Does this Household Member need health coverage?	☐ **Yes**	☐ **No** *If no, skip to "Current Job & Income Information" below.*
34. Does this Household Member have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.), a special healthcare need, or live in a medical facility or nursing home?	☐ **Yes**	☐ **No**
35. Is this Household Member a U.S. citizen or U.S. national?	☐ **Yes** *If yes, skip to question 41.*	☐ **No**
36. Is this Household Member a naturalized citizen? *If yes, list their Alien Number and Certificate Number below:*	☐ **Yes** *If yes, please list their Alien Number and Certificate Number, then skip to question 41.*	☐ **No**
Alien Number:		
Certificate Number:		

Household Member Information		
37. If this Household Member is not a U.S. citizen or national, do they have an eligible immigration status? *If yes, complete the section below:*	☐ **Yes**	☐ **No** *If no, skip to question 41.*
Immigration Document Type:		
ID Number:		
Status Type *(optional):*		
Name *(as shown on their immigration document)*:		
Alien or I-94 Number:		
Card or Passport Number:		
SEVIS ID or Expiration Date *(optional)*:		
Other *(category code or country of issuance)*:		

38. Does this Household Member also have any of these documents? *(select all that apply)*

- ☐ Certification from U.S. Department of Health and Human Services (HHS)
- ☐ Certificate from the Office of Refugee Resettlement
- ☐ Office of Refugee Resettlement Eligibility Letter (if under 18)
- ☐ Cuban/Haitian Entrant
- ☐ Resident of American Samoa
- ☐ Battered spouse, child, or parent under Violence Against Women Act
- ☐ Document indicating member of federally recognized Indian tribe or American Indian born in Canada
- ☐ Document indicating withholding of removal
- ☐ None of these

Household Member Information		
39. Has this Household Member had primary residence in the U.S. since 1996?	☐ **Yes** *If yes, skip to question 41.*	☐ **No**
40. Has this Household Member had their current immigration status for the last 5 years?	☐ **Yes**	☐ **No**
41. Is this Household Member, or their spouse or parent, an honorably discharged veteran, or an active-duty member of the U.S. military? *(optional)*	☐ **Yes**	☐ **No**
42. Does this Household Member want help paying for medical bills from the last 3 months? *If yes, list the name of the tax filer below:*	☐ **Yes**	☐ **No**
Name:		
43. Does this Household Member live with at least one child under the age of 19, and is this Household Member the primary person taking care of this child? *If yes, list the names of the children and the Household Member's relationship to them below:*	☐ **Yes**	☐ **No** *If no, skip to "Current Job & Income Information" below.*

Name:	**Relationship:**
Name:	**Relationship:**
Name:	**Relationship:**
Name:	**Relationship:**

44. Is this Household Member a full-time student?	☐ **Yes**	☐ **No**
45. Was this Household Member in foster care at age 18 or older? *If yes, please list the age this Household Member left foster care below:*	☐ **Yes**	☐ **No** *If no, skip to question 47.*
Age:		

Household Member Information		
46. During their time in foster care, did this Household Member receive Medicaid from the State? *If yes, please list which State below:*	☐ **Yes**	☐ **No**
State:		
47. Is this Household Member an American Indian or Alaska Native?	☐ **Yes** *If yes, complete Appendix B.*	☐ **No**
48. Is this Household Member of Hispanic/Latino ethnicity? *(optional)*	☐ **Yes**	☐ **No**
49. What is this Household Member's race? *(optional; select all that apply)*	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ Other: Asian ☐ Other: Pacific Islander ☐ Other: _____	

Help Paying for Coverage

*Answer the question below to indicate whether this **Household Member** wants help paying for coverage.*

- *If "Yes" is selected, this **Household Member** will be assessed for eligibility for subsidies that could lower their cost of health insurance and for Georgia Medicaid and/or PeachCare for Kids®.*
- *If "No" is selected, skip the "Current Job & Income Information" section below for this **Household Member**. This **Household Member** will not be considered for subsidies or for Georgia Medicaid and/or PeachCare for Kids® and will be applying for full-cost insurance.*

Does this Household Member want to be considered for financial assistance to help pay for health coverage?	☐ **Yes**	☐ **No** *If no, skip to Step 4.*

Current Job & Income Information

*Provide information about any income the **Household Member** receives. Skip this section if "No" was selected as the answer the question above about being considered for financial assistance to help pay for health coverage.*

Employment Status		
☐ **Yes, Employed** *Continue with "Current Job 1."*	☐ **Yes, Self-Employed** *Skip to "Self-Employed" section, below "Current Job 2."*	☐ **Not Employed** *Skip to "Other Income" section, below 'Self-Employed."*

Current Job 1			
1. Employer Name			
2. Employer Address			
3. City	**4. State**	**5. Zip Code**	**6. Employer Phone Number**

7. Wages/Tips *(before taxes)*	***8.* Frequency of Pay**	**9. Average hours worked each week**
$	☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a Month ☐ Yearly	

Current Job 2 *(if applicable)*

If this Household Member has more than two current jobs, please attach another sheet of paper containing the information requested below for each additional job.

1. Employer Name			
2. Employer Address			
3. City	**4. State**	**5. Zip Code**	**6. Employer Phone Number**

7. Wages/Tips *(before taxes)* $	**8. Frequency of Pay** ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Twice a Month ☐ Yearly	**9. Average hours worked each week**

Self-Employed

1. Type of Work	**2. How much net income *(profits once business expenses are paid)* will this Household Member get from this self-employment this month?** $

Other Income *Select all that apply and give the amount and how often this Household Member receives the income. This Household Member does not need to report income from child support, veteran's payments, or Supplemental Security Income (SSI).*		
☐ **Unemployment**	**Amount** $	**Frequency**
☐ **Alimony Received**	**Amount** $	**Frequency**
☐ **Pension**	**Amount** $	**Frequency**
☐ **Net Farming/Fishing**	**Amount** $	**Frequency**
☐ **Social Security**	**Amount** $	**Frequency**
☐ **Net Rental/Royalty**	**Amount** $	**Frequency**
☐ **Retirement Accounts**	**Amount** $	**Frequency**
☐ **Scholarships**	**Amount** $	**Frequency**
☐ **Investment**	**Amount** $	**Frequency**
☐ **Capital Gains**	**Amount** $	**Frequency**
☐ **Other Income** *(please identify)*:	**Amount** $	**Frequency**

Deductions: *Select all that apply. Please provide the amount and how often the Household Member pays the deduction. Note: If they pay for certain payments that can be deducted on a federal income tax return, including the costs in this application, it may result in a lower cost of health coverage.*		
☐ **Alimony Paid** (***Note:*** *Only include this income if the divorce was finalized before 1/1/2019.)*	**Amount** $	**Frequency**
☐ **Student Loan Interest**	**Amount** $	**Frequency**
☐ **Other Deductions** *(please identify)*:	**Amount** $	**Frequency**
Expected Income: *Complete this question if this Household Member's income changes during the year, like if they only work at a job for part of the year or receive a benefit only for certain months.*		
Your Total Income this Year $	**Your Estimated Total Income Next Year** $	**Is this Household Member's income hard to predict?** ☐ **Yes** ☐ **No**

STEP 4: HOUSEHOLD HEALTH COVERAGE

Complete this section to provide information on healthcare coverage for the members of your household. If the space provide is not enough, make additional copies of this step and attach.

Household Health Coverage			
1. Was anyone on this application found not eligible for Medicaid or PeachCare for Kids® in the past 90 calendar days? *If yes, write the name(s) of the individual(s) and the date(s) they were found not eligible below:*		☐ **Yes**	☐ **No**
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
2. Was anyone on this application found not eligible for Medicaid or PeachCare for Kids® due to their immigration status in the last 5 years? *If yes, write the name(s) of the individual(s) and the date(s) they were found not eligible below:*		☐ **Yes**	☐ **No**
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		

Household Health Coverage			
3. Did anyone on this application apply for coverage during the most recent Open Enrollment Period or after a Qualifying Life Event (QLE)? *If yes, write the name(s) of the individual(s) and the date(s) they applied below:*		☐ **Yes**	☐ **No**
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
4. Is anyone listed on this application offered health coverage from a job? *Select "Yes"' even if the coverage is from someone else's job, like a parent or spouse, even if they do not accept the coverage. Select "No" if the only coverage offered is through the Consolidated Omnibus Budget Reconciliation Act (COBRA).*		☐ **Yes** *If yes, complete Appendix A.*	☐ **No**
5. Is anyone listed on this application offered an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)?		☐ **Yes**	☐ **No**
6. Is anyone listed on this application enrolled in health coverage now?		☐ **Yes**	☐ **No** *If no, skip to Step 5.*

Information about Current Health Coverage

*If more than two **Household Members** have health coverage now, make additional copies of the questionnaire below, complete one for each additional **Household Member** and attach.*

Household Member 1			
1. First Name	**2. Middle Name** *(if applicable)*	**3. Last Name**	**4. Suffix**

5. Type of Coverage *(select one)*	☐ Employer Insurance *(if selected, answer question 6 below)* ☐ COBRA ☐ Medicaid ☐ PeachCare for Kids® ☐ Medicare ☐ TRICARE ☐ VA Health Care Program ☐ Retiree Health Benefits ☐ Peace Corps ☐ Other: _____ *(if selected, answer questions 7 and 8 below)*
6. If "Employer Insurance" was selected above, please write the name of the health insurance company and policy/ID number below *(you'll also need to complete Appendix A)*:	
Name of health insurance company:	**Policy/ID Number:**
7. If "Other" was selected above, please write the name of the health insurance company and policy/ID number below:	
Name of the health insurance company:	**Policy/ID Number:**

8. If "Other" was selected above, is this a limited-benefit plan, like a school accident policy?	☐ **Yes**	☐ **No**

Household Member 2			
1. First Name	**2. Middle Name** *(if applicable)*	**3. Last Name**	**4. Suffix**

5. Type of Coverage *(select one)*	☐ Employer Insurance *(if selected, answer question 6 below)* ☐ COBRA ☐ Medicaid ☐ PeachCare for Kids® ☐ Medicare ☐ TRICARE ☐ VA Health Care Program ☐ Retiree Health Benefits ☐ Peace Corps ☐ Other: _____ *(if selected, answer questions 7 and 8 below)*

6. **If "Employer Insurance" was selected above, please write the name of the health insurance company and policy/ID number below** *(you'll also need to complete Appendix A)*:	
Name of health insurance company:	**Policy/ID Number:**

7. If "Other" was selected above, please write the name of the health insurance company and policy/ID number below:	
Name of the health insurance company:	**Policy/ID Number:**

8. If "Other" was selected above, is this a limited-benefit plan, like a school accident policy?	☐ **Yes**	☐ **No**

STEP 5: AGREEMENT & SIGNATURE

Review the terms of Georgia Access and sign your application.

To make it easier to determine my eligibility for help paying for coverage in future years, I agree to allow Georgia Access to use my income data, including information from federal tax returns, for the next five (5) years. Georgia Access will send me a notice and let me make changes. I can opt out at any time.		
1. Do you agree to allow Georgia Access to use income data, including information from tax returns, for the next 5 years?	☐ **Yes**	☐ **No** *If no, respond to question 2 below.*
2. If you selected "No" to question 1 and do not agree to allow Georgia Access to use this income data for the next 5 years, select your preferred timeframe for Georgia Access to automatically update your information for eligibility renewals:	☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Do not use my tax data to renew my eligibility for help paying for health coverage (selecting this option may impact your ability to get help paying for coverage at renewal).	

By signing below, I understand that if anyone on my application is enrolled in Georgia Access coverage and is later found to have other qualifying health coverage (like Medicare, Medicaid, or PeachCare for Kids®), Georgia Access will automatically end their Georgia Access plan coverage. This will ensure that anyone who is found to have other qualifying coverage will not stay enrolled in Georgia Access coverage and will have to pay full cost.

By signing below, I consent to my information being shared with Georgia Medicaid for the purpose of making a Georgia Medicaid or PeachCare for Kids® eligibility determination if my application fits specific criteria to be potentially eligible or if I otherwise request a Georgia Medicaid or PeachCare for Kids® determination directly.

By signing below, I understand if anyone on this application enrolls in Medicaid, I'm giving Georgia Medicaid the right to pursue and receive any money from other health insurance, legal settlements, or other third parties. I'm also giving Georgia Medicaid rights to pursue and get medical support from a spouse, conservator, legal guardian, or parent.

By signing below, I acknowledge that, if a child on this application has a parent living outside of the home, 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 the agency, and I may not have to cooperate.

By signing below, I understand that any financial help I receive from the federal government through Advance Premium Tax Credits (APTCs) is connected to my taxes. I understand I may owe taxes, or receive more tax credits, if my income for the year is different than what I estimated. I agree to file federal income taxes (jointly if married) and report the amount of Advance Premium Tax Credits received on my tax return for any year I have federal financial help to lower premium costs.*

** This applies only to individuals who receive financial help.*

By signing below, I understand that I must notify Georgia Access within 30 calendar days if information I listed on this application changes. I know I can make changes to my Georgia Access application by calling the Georgia Access Contact Center at 1-888-687-1503 (TTY: 711). I know a change in my information could affect eligibility for me or member(s) of my household.

By signing below, I indicate that I understand that I may be able to register to vote or to update my voter registration by visiting https://mvp.sos.ga.gov/s/olvr-home.

Georgia Access does not collect voter registration information. Voter registration status in no way affects the availability or amount of assistance or services you receive from Georgia Access.

By signing below, I declare under penalty of perjury, the law of Georgia, and the laws of the United States of America that the foregoing is true and correct. I understand and acknowledge that I will be subject to penalties under both state and federal law if I knowingly or willfully provide false information in support of this application.

I understand that under federal law, discrimination is not permitted on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). I can file a complaint of discrimination by visiting https://oci.georgia.gov/file-consumer-insurance-complaint.

Signature of Primary Point of Contact	**Date Signed** *(mm/dd/yyyy)*

APPENDIX A: HEALTH COVERAGE FROM JOBS

Complete this appendix only if someone in your household is eligible for health coverage from a job, even if they do not accept the coverage. You also do not need to answer these questions if the only coverage someone is offered is COBRA. If there is more than one job that offers coverage, make a copy of this page for each job and attach.

Tell us about the household member(s) who are eligible for health care coverage from a job.

Employee			
1. First Name	**2. Middle Name** *(if* applicable*)*	**3. Last Name**	**4. Suffix**
5. SSN _____-_____-_____			
Employer Contact Information *Enter the information of the person or department who manages employee benefits. We may contact this person if we need more information.*			
6. Name	**7. Employer Identification Number (EIN)**	**8. Phone Number**	
9. Person or Department Who Manages Employee Benefits			
10. Employer Address			
11. City	**12. State**	**13. Zip Code**	
14. Employer Primary Phone Number	**15. Employer Email**		
16. Is the employee offered health coverage by this employer? *Only select "Yes" if the employee will have an offer of coverage as of the first of next month, or as of January 1 if applying during Open Enrollment.*	☐ **Yes**	☐ **No** *If no, do not answer the remainder of the questions in Appendix A.*	

Employer Contact Information		
17. Does the employer offer a health insurance plan that covers this employee's spouse or dependent(s)? *If yes, select which apply from the list below and list the names of all individuals in the employee's household who are eligible for coverage from this job.* ☐ Spouse ☐ Dependent(s)	☐ **Yes**	☐ **No**
Name:		
Name:		
Name:		
Name:		
18. Does the employer offer a health insurance plan that meets the minimum value standard?**	☐ **Yes**	☐ **No** *If no, do not answer the remainder of the questions in Appendix A.*
19. How much would the employee have to pay for the lowest cost plan offered to only the employee that meets the minimum value standard? Do not include family plans.		
Amount $	**Frequency**	

*** A health insurance plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.*

APPENDIX B: AMERICAN INDIAN OR ALASKA NATIVE (AI/AN) HOUSEHOLD MEMBERS

Complete this appendix if you or a household member are American Indian or Alaska Native and are applying for coverage. If you have more people to include, make a copy of this page and attach.

Tell us about your American Indian or Alaska Native household member(s).

American Indians and Alaska Natives can get services from the Indian Health Services (IHS), tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the questions below to make sure your household gets the most help possible.

AI/AN Household Members			
1. First Name	**2. Middle Name** *(if applicable)*	**3. Last Name**	**4. Suffix**

5. Member of a federally recognized tribe? *If yes, please list the Tribe name and State where the Tribe is located below:*	☐ **Yes**	☐ **No**
Tribe:		
State:		
6. Has this person ever received a service from the IHS, a Tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ **Yes** *If yes, skip to question 8.*	☐ **No**
7. Is this person eligible to get services from the IHS, Tribal health programs, or urban Indian health programs, or through a referral from one of these programs?	☐ **Yes**	☐ **No**

AI/AN Household Members		
8. Certain money received may not be counted for Medicaid or PeachCare for Kids®. Indicate any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a Tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance		
☐ **Unemployment**	**Amount** $	**Frequency**
☐ **Alimony Received**	**Amount** $	**Frequency**
☐ **Pension**	**Amount** $	**Frequency**
☐ **Net Farming/Fishing**	**Amount** $	**Frequency**
☐ **Social Security**	**Amount** $	**Frequency**
☐ **Net Rental/Royalty**	**Amount** $	**Frequency**
☐ **Retirement Accounts**	**Amount** $	**Frequency**
☐ **Scholarships**	**Amount** $	**Frequency**
☐ **Investment**	**Amount** $	**Frequency**
☐ **Capital Gains**	**Amount** $	**Frequency**

AI/AN Household Members		
☐ **Other Income** *(please identify)*:	**Amount** $	**Frequency**

APPENDIX C: HELP WITH COMPLETING THIS APPLICATION

Complete this appendix if you are receiving support from someone else to complete your application. Both you and the person helping you must complete this appendix.

You can choose an authorized representative to help with your application.

This person can be a friend, family member, or someone else you trust. Please note that appointing a certified Navigator or Certified Application Counselor (CAC) prohibits them from operating in their official capacity as an assister.

Your authorized representative may act on your behalf on all matters related to your application and inquiries around your health coverage, including getting information about your application and signing your application on your behalf. All communications about your application will go to your authorized representative, not you – if you ever need to change or remove your authorized representative, contact the Georgia Access Contact Center by calling 1-888-687-1503. Select one below:

☐ **No,** I am not appointing an authorized representative.

☐ **Yes,** I am appointing an authorized representative.

If you selected "Yes" above, provide the following information.

Authorized Representative Information			
1. Frist Name	**2. Middle Name** *(if applicable)*	**3. Last Name**	**4. Suffix**
5. Primary Phone Number		**6. Email**	
7. Mailing Address		**8. Mailing Address 2** *(if applicable)*	
9. City	**10. State**	**11. Zip Code**	
12. Organization Name *(if applicable)*		**13. ID Number** *(if applicable)*	
For Georgia Access Certified Agents Only			
1. Application Start Date *(mm/dd/yyyy)*		**2. NPN Number**	

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

Signature of Primary Point of Contact	**Date Signed** *(mm/dd/yyyy)*

APPENDIX D: LIFE EVENTS

Complete this appendix if you or someone in your household is applying for a Special Enrollment Period due to a Qualifying Life Event (QLE). Note that you must complete the rest of this application along with this page. Do not submit this page by itself.

If anyone on this application has experienced certain QLEs—like losing health coverage, getting married, or having a baby—in the past 60 calendar days (OR expects to in the next 60 calendar days), please fill out this page and include it with your completed, signed application. Certain QLEs allow your coverage through Georgia Access to start right away. We also recommend you answer these questions if you are applying outside Open Enrollment.

These questions are optional. If your life circumstances have not changed, you can leave the answers blank. You can apply for and, if eligible, enroll in Medicaid and PeachCare for Kids® any time of the year, even if you did not experience life events. Members of federally recognized tribes and Alaska Native shareholders can enroll in coverage through Georgia Access any time of the year.

Tell us about changes in your household.

If your response to any of the questions is "Yes," please include the relevant person's name, as well as details of the coverage date.

Life Events		
1. Did anyone lose qualifying health coverage in the last 60 calendar days, or does anyone expect to lose qualifying health coverage in the next 60 calendar days? *If yes, list the name(s) of the individual(s) and the date(s) they lost qualifying health coverage below:*	☐ **Yes**	☐ **No**

Name:	**Date Coverage Ended or Will End** *(mm/dd/yyyy)*:
Name:	**Date Coverage Ended or Will End** *(mm/dd/yyyy)*:
Name:	**Date Coverage Ended or Will End** *(mm/dd/yyyy)*:
Name:	**Date Coverage Ended or Will End** *(mm/dd/yyyy)*:

Life Events			
2. Did anyone get married in the last 60 calendar days? *If yes, write the name(s) of the individual(s) and the date(s) they got married below:*		☐ **Yes**	☐ **No** *If no, skip to question 3.*
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
a. Did any of these people have qualifying health coverage at any time in the last 60 calendar days? *If yes, write the name(s) of the individual(s) who had qualifying health coverage below:*		☐ **Yes**	☐ **No**
Name:			
Name:			
Name:			
Name:			

Life Events			
3. Did anyone get released from incarceration (detention or jail) in the last 60 calendar days? *If yes, write the name(s) of the individual(s) and the date(s) they were released below:*		☐ **Yes**	☐ **No**
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
4. Did anyone gain eligible immigration status in the last 60 days? *If yes, write the name(s) of the individual(s) and the date(s) they became eligible below:*		☐ **Yes**	☐ **No**
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		

Life Event			
5. Was anyone adopted, placed for adoption, or placed for foster care in the last 60 days? *If yes, write the name(s) of the individual(s) and the date(s) they became adopted, placed for adoption, or placed for foster care below:*		☐ **Yes**	☐ **No**
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
6. Did anyone become a dependent due to a child support order or other court order in the last 60 calendar days? *If yes, write the name(s) of the individual(s) and the date(s) they became a dependent below:*		☐ **Yes**	☐ **No**
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		

Life Events			
7. Did anyone move in during the last 60 calendar days? *If yes, write the name(s) of the individual(s) and the date(s) they moved below:*		☐ **Yes**	☐ **No** *If no, skip to question 6.*
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
Name:	**Date** *(mm/dd/yyyy)*:		
a. What is the zip code of the previous address?	☐ **Select here if the move was from a foreign country or U.S. territory**		
b. Did any of these people have qualifying health coverage at any time in the last 60 calendar days? *If yes, write the name(s) of the individual(s) below:*		☐ **Yes**	☐ **No**
Name:			
Name:			
Name:			
Name:			

Life Events		
8. **Did anyone become newly eligible for an employer health reimbursement arrangement: Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)?** *If yes, write the name(s) of the individual below:*	☐ **Yes**	☐ **No**
Name:		
Name:		
Name:		
Name:		