SAVANNAH TECHNICAL COLLEGE

Note: This is a Pre-Screening form to determine benefits eligibility for community resources (SNAP, Medicaid, PeachCare for Kids, CAPS, etc)

Here is what you need to do to see if you are eligible:

- Complete the Screening Application
- Sign the Authorization and Consent to Release Information Form
- Return the screening application to your SNAP Benefits Representative

(Application can be dropped off at the Main Campus- LEC Front Desk or the Student Affairs Office at any STC campus OR can be electronically filled and emailed to need email of new SNAP Outreach Specialist)

Date: _____

Name: _____ **Date of Birth:** _____

☐**Male** ☐**Female** **US Citizen:** ☐ Yes ☐ No **Marital Status:** ☐ Married ☐Single

Primary Phone #: _____ **Alternate Phone #:** _____

Home Address: _____

City: _____ **Zip:** _____ **County:** _____

Email: _____

Please indicate the best time to contact you: ☐ Morning ☐ Afternoon

Household size: _____ *(List all members whom live in your home AND you share food with)*

Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____
Name: _____ DOB: _____ Relationship: _____

Please indicate whether you OR anyone in your household:

1. **CURRENTLY RECIEIVES** any of the following benefits? ***Please check all that apply:***

Food Stamps	☐Yes ☐No	CAPS	☐Yes ☐No
Medicaid	☐Yes ☐No	WIC	☐Yes ☐No
PeachCare for Kids	☐Yes ☐No	TANF	☐Yes ☐No

2. **How did you hear about Savannah Technical College's SNAP Resource? (Please Check One)**
   ☐ **Adult Ed** ☐ **Email** ☐ **Electronic Board** ☐**Website** ☐ **College 1010** ☐ **Brochure**
   ☐ **Other (write in space provided)**_____

*****IF YOU ALREADY RECEIVE *WANTED* BENEFITS *STOP* HERE- The above information will be used to help you with your renewals and to advocate on your behalf. If you aren't sure if you are eligible for other benefits, go ahead and continue filling out the screening. *****

CONTINUE ON REVERSE SIDE

3. Anyone pregnant? : ☐Yes ☐No
   Name(s):_____
4. Anyone breastfeeding an infant less than 12 months old? : ☐Yes ☐No
   Name(s)_____
5. Anyone not breastfeeding, but pregnancy ended less than 6 months ago? :
   ☐Yes ☐No Name(s) _____
6. Anyone enrolled in Medicare? ☐Yes ☐No Name(s)_____
7. Anyone a guardian of any children in your household? : ☐Yes ☐No Name(s)_____
8. Anyone considered disabled or blind through the Social Security Administration?: ☐Yes ☐No
   Name(s):_____
9. Anyone living in a nursing home? : ☐Yes ☐No Name(s)_____
10. Does any child in your household have Health Insurance? : ☐Yes ☐No Name(s)_____
11. Did any child in your household have Health Insurance within the last 2 months? :
    ☐Yes ☐No Name(s) _____
12. Do any children aged 13-18 have special needs? : ☐Yes ☐No Name(s):_____
13. Anyone disabled and caring for a child less than 5 years of age? : ☐Yes ☐No Name(s):_____
14. Anyone working, looking for work, or in a training program **AND** caring for a child? :
    ☐Yes ☐No Name(s):_____
15. Is any adult a caretaker for a minor child? ☐Yes ☐No Name(s):_____
16. Anyone **60 or older** and caring for a child? ☐Yes ☐No Name(s):_____
17. Is anyone a student caring for a child? ☐Yes ☐No Name(s):_____

Employment/Assets:

18. Please list each working household member's place(s) of **CURRENT employment**, hours, and payment information.

    Household Member #1 Name: _____
    Place(s) of Employment: _____
    Hours per week: _____
    Work Earnings:
    Amount: $_____ **Frequency (circle one)**: (weekly/biweekly/monthly/yearly)
    Rate: $_____ (hourly/salary) **Monthly Income (before taxes)**: $_____

    Household Member #2 Name: _____
    Place(s) of Employment: _____
    Hours per week: _____
    Work Earnings:
    Amount: $_____ **Frequency (circle one)**: (weekly/biweekly/monthly/yearly) **Rate**: $_____ (hourly/salary) **Monthly Income (before taxes)**: $_____

Household Member #3 Name: _____
Place(s) of Employment: _____
Hours per week: _____
Work Earnings:
Amount: $_____ **Frequency (circle one)**: (weekly/biweekly/monthly/yearly)
Rate: $_____ (hourly/salary) **Monthly Income (before taxes)**: $_____

19. How much does the household receive in **OTHER** earnings (**i.e. SSI/SSA, Unemployment, Cash, Gifts, or Contributions, Alimony, Rental, Retirement, Child Support, or other income etc**)?

Household Member #1 Name: _____
Type of Income (see "i.e" above and write in): _____ **Amount:** $_____
Frequency (circle one): (weekly/biweekly/monthly/yearly)

Household Member #2 Name: _____
Type of Income (see "i.e" above and write in): _____ **Amount:** $_____
Frequency (circle one): (weekly/biweekly/monthly/yearly)

Household Member #3 Name: _____
Type of Income (see "i.e" above and write in): _____ **Amount:** $_____
Frequency (circle one): (weekly/biweekly/monthly/yearly)

Housing Expenses:

20. Do you pay ☐Rent or ☐Mortgage?
How much? _____ (weekly/biweekly/monthly)
21. Does your household pay for heating and/or cooling expenses? ☐Yes ☐No

If you have *specific needs* please write them below:

We will notify you once your screening application has been completed. Please remember to check your email and/or voicemail regularly for any benefit correspondences.

Authorization and Consent to Release Information

By signing my name below: I, _____, grant permission to Savannah Technical College (STC), to give and share and make use of the following information about me with their affiliates which include employees, subcontractors, Community Based Organization partners and vendors (including the Gateway Screening Service), in order to assist me in determining my eligibility for benefits offered by the City of Savannah, the State of Georgia, the federal government and/or other non-profit organizations and other related benefits included in the Gateway software.

Such information includes but is not limited to, the following:

- My name and social security number, address, and related personal information;
- The name and social security number and related personal information of any of my dependents or household members;
- Whether or not I, or any of my dependents now receive any form of public benefits;
- If so, how much I or my dependent(s) receive and when I or my dependent started getting them;
- If I, or my dependent(s), was not approved to receive benefits, the reason for the denial or why no action was taken;
- If I or my dependent(s) stopped receiving benefits, when the benefits stopped and why; and
- Any information necessary to complete the application for a type of benefits for myself or a dependent or member of my household completely and accurately.

I give this permission so that STC, their partners and their employees, affiliates, subcontractors and partners can pre-screen me and my dependent(s) for and assist me and my dependent(s) in obtaining public and other benefits using the Gateway screening Software.

I give permission to local or state governmental benefits-determining agencies to discuss my application progress with STC and its affiliates (as defined above) in order to determine my application status and to provide me with records and information concerning me, including but not limited to whether benefits were approved or denied, that may be under the custody and control of such local or state governmental benefits-determining agencies.

I understand that STC and its affiliates (as defined above) shall keep any information confidential and will not reveal or give it to anyone else without my permission. I also understand that STC shall make reasonable efforts to ensure that its affiliates (as defined above) keep any information confidential and will not reveal or give it to anyone else without my permission.

I understand and agree that STC and its affiliates (as defined above) may use this information for research and reporting purposes. However, my personal information will not be revealed except as required by the lawful order or requirement of a governmental agency or court of competent jurisdiction, or as otherwise required by law.

I further certify that any information I provide will be true and accurate to the best of my knowledge.

By signing my name below I also certify that I have read this consent form or someone has read it to me. This consent will be effective unless and until I end it in a writing signed by me.

Sign (By Hand or Type): _____ Date: _____

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider