S2S Facts, Senior Citizens Necessity Pantry (SCNP)

Application Packet

The SCNP is a SOCIAL DETERMINANTS OF HEALTH PROGRAM (SDOH) for senior citizens. Coronavirus has caused many deaths, sickness, record numbers of unemployed, and a change of how day to day operations occur. S2S Facts stands committed to adhering to our mission of "Building tomorrow's future, today" even during this tragic public health outbreak. Therefore, in alignment of our 4point thrust of our social responsibility to the community, we launch the SCNP to serve those underserved senior citizens with limited mobility and transportation.

Criteria

1. **Applicant must be in one of the below groups.**
    a. 60yrs of age or Older
    b. Receiving Disability or SSI benefits
2. **Limited one application per household (If spouse in household add relevant information to the application)**
3. **Necessity pack contents. Please note items may vary**
    a. Adult Undergarment
    b. Personal Hygiene Products
    c. Non-perishable snack foods
    d. Entertainment Trinket(s) (Large face coloring book/stress ball/etc.)
    e. Misc. (items that may not be common on a month/month basis, ex: grab sticks, water gripper bottles, etc.)
4. **Verification Information:**
    a. Birth Certificate/SSN card/or SSI/Disability letter, etc.

P.O. Box 18364 Sav. Ga. 31408. Contact us via email: info@s2sfactsinc.com
phone 912-429-6599: Website: www.s2sfactsinc.com

Find us on Facebook @s2sfacts

SENIOR CITIZENS NECESSITY PANTRY (SCNP) Application

Part 1. Personal Information

VERIFICATION DOCUMENT	The Verification document/information disclosed is kept safe, SS# are not shared with any unnecessary outside entity. This information is strictly used for verification of eligibility for the SCNP program, verify information supplied on the application, to prevent, detect, and correct fraud, waste, and abuse, and for the purpose of responding to requests for information from agency programs funded by block grants to states for assistance within the program. Note some demographic information maybe subject to share with funding sources as a fulfillment of program funding requirements.

Your Name: MM - DD – YYYYY

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First Name M.I. Last Date of Birth

2nd Household Name: MM - DD – YYYYY

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First Name M.I. Last Date of Birth

Current Home Address

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Street #Apt City State Zip Code

Mailing Address (If different from home address)

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Street or PO Box #Apt City State Zip Code

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County: Township:

Home Phone: Other Phone: E-Mail Address:

(.....)..... (.....)..... .....

To contact me in writing, I prefer ☐ Email ☐US mail (letter)

Primary Language spoken in home: .....

YOU MUST SIGN AND DATE THIS APPLICATION AT THE BOTTOM OF THE LAST PAGE

S2S FACTS, INC
Sistahs to Sisters Unite

Part 2. Household Information

LIST ALL HOUSEHOLD MEMBERS, STARTING WITH YOU:

***Head of household should be placed on the first line item #SSN required.**

First Name, M.I, & Last Name	SSN	Date of Birth MM-DD-YYYY	RACE	Sex M/F	Disability Y/ N	Veteran Y/N	Have Income Y/N
	n/a						
	n/a						
	n/a						
	n/a						
	n/a						
	n/a						

Attach a separate sheet if necessary, for any additional household members.

Race: A = Asian B = Black or African American I = American Indian or Alaska Native P = Native Hawaiian or Other Pacific Islander W = White M = Multi Race O = Other H = Hispanic

Part 3. Housing Information

Type of Housing:	Do you pay for rent or mortgage? ☐ Yes ☐ No If yes, amount ($) …… (required)
☐ House ☐Apartment/Condo ☐Townhouse ☐Mobile Home ☐Duplex ☐Triplex ☐Fourplex ☐ Other	**Renters:** Do you get a rent subsidy, or do you live in subsidized housing? ☐Yes ☐No Is heat included in your rent? ☐Yes ☐No Is electricity included in your rent? ☐ Yes ☐No Landlord's How long have you lived in your current home? …….. Years …….. Months Name: …… Phone: (……) …….. Address:……..
	Do you have any allergies: ☐ Yes ☐ No If yes, please list all
	Are you allergic to anything? ☐Yes ☐No If Yes, please list all

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Part 5. Consent and Signature for May 1, 2020 to December 15, 2020.

1. I give my consent for S2S Facts, Incorporated staff, volunteers, representatives etc. to deliver necessity packs to my residents.

2. I promise to ensure a safe environment for the S2S Facts, Incorporated staff, volunteers, representatives, etc. when delivering the necessity packs. (all animals placed in safely away, no violence, guns, or any harmful gestures/persons/etc.)

3. I authorize S2S Facts, Incorporated staff, volunteers, representatives, etc. to verify information as needed.

If It's rent, to contact my landlord to confirm my residency and/or heating source.

4. I authorize my local S2S Facts, Incorporated SCNP Service Providers to contact me for promotion (video/commercial ad) or referrals, with the understanding you as the client have the right to refuse any such offer without losing or impacting delivery in any way of the SCNP program.

5. By signing, I affirm that all data in this application is correct. I also acknowledge that: ☐ I currently reside in the address listed on this application. I am signing on behalf of all household members. ☐ I may have to prove my statements. ☐ I may be held civilly or criminally liable under federal or state law for knowingly making false or fraudulent statements. ☐ I have rights under SCNP I have received a copy of the "Privacy Notice and Your Rights and Responsibilities" and agree to its terms and conditions. ☐ I understand that filling out this application does not guarantee that my household will receive assistance. ☐ I am an elderly adult or meet one of the above-mentioned criteria.

Print Name: ……..

Signature:…… Today's Date:……

We must receive your application within 60 days of the date you sign it. This application must be postmarked or received no later than December 5, 2020. Funds may not last, apply early.

Privacy Notice and Your Rights and Responsibilities

Privacy Notice Privacy Act Provisions: Federal and state laws require us to tell you about your rights and responsibilities before we collect and use information about you that is classified as private or confidential. This form provides you with important information that complies with the federal Privacy Act of 1974, 5 U.S.C. § 552a(e)(3)

Fraud, Waste, and Abuse Notice

***Note: the below information source is The Georgia Collaborative ASO WEBSITE: (https://www.georgiacollaborative.com/fraud-and-abuse/) ***

We ask that anyone who suspects fraud, waste or abuse report it. We have included the definitions of fraud, waste and abuse so you will know the type of information to report.

Fraud: Intentionally submitting false information to the government or a government contractor to get money or a benefit. Fraud, in other words, is doing something wrong, and sometimes illegal, to bring money or favors to a healthcare organization.

Waste: Overutilization of services or other practices that directly or indirectly result in unnecessary costs to healthcare programs, such as Medicaid or Medicare.

Abuse: Actions, although unintentional, which may directly or indirectly result in unnecessary costs healthcare programs, such as Medicaid or Medicare. In healthcare, abuse may include things such as poor business practices that may increase the price of services or getting paid for services that are not high quality or that someone really did not need.

Some activities that are high risks for Fraud, Waste, and Abuse violations include the following:

- Submitting a false claim that a provider uses to receive payment for a service.
- Submitting a claim for a service that did not occur.
- Using the wrong billing code in order to be paid more.
- Billing for a longer period of time than was actually spent delivering the service.
- Billing for a service that really was not needed.
- Taking or giving bribes, which could be money or gifts, so the provider will get more business or other favors.
- Paying someone so they will give you more business or individuals to serve.
- Submitting a claim with inadequate or poor documentation to support the service that was billed; or

- Making up a record to pretend that a service or treatment was provided, even though it was not.

Report Potential Fraud

- **Beacon Health Options:**

  Report By Mail:

  Beacon Health Options

  Attn: Compliance Officer

  229 Peachtree Street, NE

  18th floor

  Atlanta, GA 30303

  Report By Phone:

  888-293-3027

  Additional numbers TBD

  Report By E-mail:

  TBD

  Georgia Office of Inspector General:

  Report By Mail:

  Office of Inspector General

  ATTN: Special Investigations Unit

  2 Peachtree Street, NW 5th Floor

  Atlanta, GA 30303

  Report By Phone:

  404-463-7590

  800-533-0686

  Report By E-mail:

  oiganonymous@dch.ga.gov or

  ReportMedicaidFraud@dch.ga.gov or

  Report fraud using online form.