Ohio Department of Medicaid

APPLICATION FOR HEALTH COVERAGE & HELP PAYING COSTS

Apply faster online

Apply faster online at **benefits.ohio.gov** or **Healthcare.gov**.

Use this application to see what you qualify for

- Free or low-cost insurance from Medicaid for adults and children
- Help with paying Medicare-related costs such as monthly premiums
- Affordable private health insurance plans that offer full coverage to help you stay well. Filling out this application does not mean you have to buy health coverage.
- A tax credit that can help pay your premiums for private health coverage

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you, your spouse, or your child already have health coverage. You could be eligible for lower-cost or free coverage.
- Families that include non-citizens can apply. You can apply for your child even if you're not eligible for coverage. Applying will not affect your U.S. citizenship status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to fill out APPENDIX C.

What you may need to apply

- Social Security Numbers (or document numbers for any qualified non-citizens who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about your income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law**.

ODM may use or disclose member information consistent with the notice of privacy practices, available on the ODM website.

To view the ODM Notice of Privacy Practices, visit:
https://medicaid.ohio.gov/wps/portal/gov/medicaid/families-and-individuals/coverage/already-covered/rights/notice-of-privacy-practices

What happens next?

Send your completed, signed application to your local county JFS office.
Find your county office here: https://jfs.ohio.gov/about/local-agencies-directory

If you do not have all the information we ask for, sign and submit your application anyway.
If you do not hear from us within 45 days, you may call **1-844-640-OHIO (6446).**

Get help with this application

- **Online**: **benefits.ohio.gov** or **Healthcare.gov**
- **Phone**: **1-844-640-OHIO (6446) or TTY 1-800-292-3572**
- **In Person**: Contact your local county JFS office
- **En Español**: **1-844-640-OHIO (6446)**

To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to: oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling the Medicaid Consumer Hotline 1-800-324-8680; individuals with a hearing impairment may call TDD 7-1-1.

Medicaid Estate Recovery

If you're permanently institutionalized or age 55 or older when you receive Medicaid benefits, after your death the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the capitation payments that Medicaid pays to your managed care plan, even if the capitation payments are greater than the cost of the services you actually received. **https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM07400.pdf**

Your Civil Rights

The Ohio Department of Medicaid (ODM) complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, race, color, religion, sex, national origin, ancestry, disability, veteran status, sexual orientation, military status, or genetic information. Individuals eligible for, receiving services from, or benefiting from programs funded through the Ohio Department of Medicaid are protected by law against unlawful discrimination.

ODM:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Ohio Department of Medicaid's consumer hotline at 800-324-8680.

If you believe that ODM has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Civil Rights Coordinator
P.O. Box 182709
Columbus, Ohio 43218-2709
614-995-9981/TTY 711, Fax 1-614-644-1434
Email: ODM_EEO_EmployeeRelations@medicaid.ohio.gov.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
800–368–1019, (TDD: 800–537–7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Register to Vote

Would you like to register to vote? If yes, a Voter Registration and Information Update Form is included with this application. If you would like to register to vote, you may fill out the form and mail it to the Ohio Secretary of State at the address below. You may also fill out the form online: https://olvr.ohiosos.gov. Or you may download an electronic copy of the form: https://www.sos.state.oh.us/publications/#vrf.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. You may contact the toll-free Help Desk (1-844-640-OHIO) or the Ohio Secretary of State's toll-free number (1-877-SOS-OHIO/1-877-767-6446). You may also call or visit your local county JFS office. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you have not received any verification of your voter registration from the county board of elections in which you reside within 21 days from the date you registered, you may inquire about the status of your registration by contacting your county board of elections.

If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the prosecuting attorney or with the Secretary of State:

Ohio Secretary of State
180 E. Broad Street
Columbus, OH 43215
(614) 466-2585
Toll Free: (877) 868-3874

To locate your county prosecutor's contact information, you may review a roster of county prosecutors online at http://www.ohiopa.org/roster.html or you can call the Ohio Prosecuting Attorneys Association at (614) 221-1266.

HEALTH COVERAGE PROGRAMS

Ohio has several types of health care services. Below is a short description of health coverage programs that are available in Ohio. Families can apply for one or all of the following programs using the attached application.

Medicaid for Adults, Children, or Families

The Medicaid for Adults, Children, or Families program provides health care coverage that includes doctor visits, hospital care, pregnancy-related services, prescriptions, vision, dental, substance abuse treatment, mental health services, and much more. These are important health care services that you and your family need to stay healthy and strong. For more information, please call 1-800-324-8680 or visit **Medicaid.ohio.gov**.

Medicaid for the Aged, Blind, or Disabled

The Medicaid for the Aged, Blind, or Disabled (ABD) program provides health care coverage that includes primary and acute-care benefit packages for older adults and people with disabilities. To qualify for ABD Medicaid, applicants must be: age 65 or older; or considered legally blind; or an individual with a disability (as classified by the Social Security Administration); and must meet basic requirements. For more information, please call 1-800-324-8680 or visit **Medicaid.ohio.gov**.

Long-Term Care

Long-term services and supports are programs or services that help older adults and people with disabilities complete everyday tasks. These tasks may include bathing, getting dressed, fixing meals, and managing a home. Long-term services and supports allow individuals to live healthy, secure, and independent lives either in a long-term care facility or in a home and community-based setting. For more information, please call 1-800-324-8680 or visit **Medicaid.ohio.gov**.

Medicare Premium Assistance Programs

The Medicare Premium Assistance Programs (MPAP) help people who are eligible for Medicare and have limited income or assets get help with paying their Medicare premiums, deductibles, co-pays, and/or coinsurance. For more information, please call 1-800-324-8680 or visit **Medicaid.ohio.gov**.

ADDITIONAL HEALTH COVERAGE PROGRAMS

Help Me Grow (HMG)

The Help Me Grow Home Visiting program provides parenting education for pregnant women and new parents. The program helps families with young children connect with resources so that children start school healthy and ready to learn. The Help Me Grow Early Intervention program provides services to families with children birth to age three with developmental delays or disabilities. Services are coordinated and families are connected to services which build the parents' ability to enhance their child's development so that children with disabilities or delays in development start school healthy and ready to learn. For more information, visit https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/help-me-grow/help-me-grow or call 1-800-755-GROW (4769). Help Me Grow programs are managed by the Ohio Department of Health.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC helps income eligible pregnant and breastfeeding women, women who recently had a baby, infants, and children up to five years of age who are at health risk due to inadequate nutrition. To be eligible for WIC, you must be a woman who is pregnant or breastfeeding or have a baby less than six months old. Children from birth to age 5 also qualify. Families must meet WIC income and medical or nutritional risk guidelines. To apply, complete the attached application; visit your local WIC clinic; visit https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/women-infants-children/resources/women-infants-children-description; or call 1-800-755-GROW (4769). The WIC program is managed by the Ohio Department of Health.

STEP 1 **Tell us about yourself (the applicant)**

Complete this section for you or for the person for whom you are applying. We need one adult in the family to be the contact person for your application.

1. First name	Middle name	Last name	Suffix

2. Home address ☐ Check here if you are Homeless			3. Apartment or suite number
4. City	**5. State**	**6. Zip code**	**7. County**
8. Mailing address *(if different from home address)*			9. Apartment or suite number
10. City	**11. State**	**12. Zip code**	**13. County**
14. Phone number		15. Other phone number	

16. Do you want to get information about this application by e-mail? ☐ Yes ☐ No

E-mail address:

17. What is your preferred spoken or written language *(if not English)*?

18. **VOTER REGISTRATION APPLICATION ATTACHED**

If you are not registered to vote where you live now, would you like to apply to register to vote today?

☐ **Yes**, I want to register. ☐ **No**, I do not want to register to vote.

If you do not check either box, you will be considered to have decided not to register to vote at this time.

Applying to register or declining to register to vote will not affect the amount of assistance that you'll be provided by this agency.

19. For which health coverage programs would you like to apply?

For information about these programs, please see Page 4.

☐ Medicaid for Adults, Children, or Families ☐ Medicaid for the Aged, Blind, or Disabled *(Also complete **APPENDIX E**)*

☐ Long-Term Care (Also complete **APPENDIX E**) ☐ Medicare Premium Assistance Programs *(Also complete **APPENDIX E**)*

20. For which additional programs would you like to apply?

For information about these programs, please see Page 4.

☐ Help Me Grow (HMG) ☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

STEP 2 Who do you need to include on this application?

Do include	
Yourself	Your spouse
Your children under age 21 who live with you	Your unmarried partner who needs health coverage
Anyone you include on your tax return, even if they don't live with you (you don't need to file taxes to get health coverage)	Anyone else under age 21 who you take care of and who lives with you.
Anyone else who lives with you, but is temporarily absent and there is a definite plan for their return	

You DO NOT have to include	
Your unmarried partner who doesn't need health coverage, unless you have a common child who lives with you	Your parents who live with you, but file their own tax returns (if you are over age 21)
Your unmarried partner's children	Other adult relatives who file their own tax returns

The amount of assistance or the type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than two people in your family, you will need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We will use personal information only to check if you're eligible for health coverage.

STEP 2: Person 1 Start with yourself

1. First name	Middle name	Last name	Suffix	2. Relationship to you **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN)

We need this if you want health coverage and have an SSN. Even if you don't want health coverage, providing your SSN is helpful because it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. For help with getting an SSN, call 1-800-772-1213 or visit **ssa.gov**.
TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. Please answer questions a-c. ☐ No. Skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, list name of spouse:

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you married? ☐ Yes ☐ No

8. **Do you want health coverage?** Even if you have insurance, there might be a program with better coverage or lower costs.

☐ Yes. *Answer questions 9-23*. ☐ No. *Skip to the income questions in STEP 3.*

9. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

STEP 2: Person 1 **(Continue with Person 1)**

10. Do you have a medical condition that limits one or more daily activities (like bathing, dressing, daily chores, etc.)?
☐ Yes Please also complete **APPENDIX E**. ☐ No

11. Are you requesting in-home care or nursing home care?
☐ Yes Please also complete **APPENDIX E**. ☐ No

12. Are you pregnant? ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? Expected due date (*optional*):

13. If not currently pregnant, were you pregnant recently? ☐ Yes ☐ No
If yes, how many babies were expected during that pregnancy? Pregnancy end date:

14. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No **If yes,** are you a naturalized or derived citizen? ☐ Yes ☐ No

15. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below. ☐ No

Document Type:	Document ID Number:
Have you lived in the U.S. since August 22, 1996? ☐ Yes ☐ No	Are you, your spouse, or your parent(s) a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16. If you live with at least one child under the age of 19, are you the main person taking care of this child? ☐ Yes ☐ No

17. Are you going to school, college, or in training? ☐ Yes ☐ No. **If yes**, please provide the following information.

Type of school: ☐ College/Higher Education ☐ Vocational ☐ GED ☐ Technical Training

Enrollment: ☐ Full Time ☐ Half Time ☐ Less than Half Time

18. Were you in foster care at age 18 or older? ☐ Yes ☐ No

a. **If yes**, when did you enter foster care? _____

b. When did you leave foster care? _____

c. In which state were you in foster care? _____

19. Are you currently incarcerated (detained or jailed)? ☐ Yes ☐ No

If yes, please provide date of incarceration: Expected date of release (*optional*):

20. Are you currently or have you ever served in the military? ☐ Yes ☐ No

21. Are you currently or did you previously receive benefits in another state? ☐ Yes ☐ No
If yes, where?

22. Are you Hispanic or Latino? (OPTIONAL – check all that apply)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

23. RACE (OPTIONAL – check all that apply)

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese

☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

☐ Other _____

STEP 2: Person 2

Complete STEP 2 for your spouse/partner and children who live with you, and/or anyone listed on your federal income tax return if you file one. See page 6 for more information about who to include. If you don't file a tax return, remember to add all family members who live with you.

1. First name	Middle name	Last name	2. Relationship to you

3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female	5. Social Security Number (SSN) **We need this if PERSON 2 wants health coverage and has an SSN.**

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?
(PERSON 2 can still apply for health insurance even if he or she doesn't file a federal income tax return.)
☐ Yes *Please answer questions a-c.* ☐ No *Skip to question c.*

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, list name of spouse:

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents:

c. Will PERSON 2 be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 married? ☐ Yes ☐ No

9. Does PERSON 2 want health coverage? Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs. ☐ Yes. *Answer questions 10-24.* ☐ No. *Skip to the income questions in STEP 3.*

10. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

11. Does PERSON 2 have a medical condition that limits one or more daily activities *(like bathing, dressing, daily chores, etc.)?*
☐ Yes. *Please also complete APPENDIX E.* ☐ No.

12. Is PERSON 2 requesting in-home care or nursing home care?
☐ Yes. *Please also complete APPENDIX E.* ☐ No.

13. Is PERSON 2 pregnant? ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? Pregnancy end date:

14. If not currently pregnant, was PERSON 2 pregnant recently? ☐ Yes ☐ No
If yes, how many babies were expected during this pregnancy? Pregnancy end date:

15. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No
If yes, is PERSON 2 a naturalized or derived citizen? ☐ Yes ☐ No

16. If PERSON 2 is not a U.S. citizen or U.S. national, do they have eligible immigration status?
☐ Yes. *Fill in PERSON 2's document type and ID number below.* ☐ No

Document Type:	Document ID Number:

Has PERSON 2 lived in the U.S. since August 22, 1996? ☐ Yes ☐ No	Is PERSON 2, his/her spouse, or his/her parent(s) a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

17. If PERSON 2 lives with at least one child under the age of 19, is he or she the main person taking care of this child?
☐ Yes ☐ No

18. Is PERSON 2 going to school, in college, or in training? ☐ Yes ☐ No **If yes**, please provide the following information:
Type of school: ☐ College/Higher Education ☐ Vocational ☐ GED ☐ Technical Training
Enrollment: ☐ Full Time ☐ Half Time ☐ Less than Half Time

Step 2: Person 2 **(Continue with Person 2)**

19. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No
    a. **If yes**, when did PERSON 2 enter foster care? _____
    b. When did PERSON 2 leave foster care? _____
    c. In which state was PERSON 2 in foster care? _____

20. Is PERSON 2 currently incarcerated *(detained or jailed)*? ☐ Yes ☐ No
    If yes, please provide date of incarceration: _____ Expected date of release *(optional)*: _____

21. Is PERSON 2 currently or has PERSON 2 ever served in the military? ☐ Yes ☐ No

22. Is PERSON 2 currently receiving or has PERSON ever received benefits in another state? ☐ Yes ☐ No
    If yes, where? _____

23. Is PERSON 2 Hispanic or Latino? *(OPTIONAL – check all that apply.)*
    ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

24. RACE *(OPTIONAL – check all that apply)*
    ☐ White ☐ Black or African American
    ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese
    ☐ Filipino ☐ Japanese ☐ Korean
    ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
    ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander
    ☐ Other _____

STEP 3

Current Job & Income Information for All Household Members

☐ **Employed**	☐ **Self-Employed**	☐ **Not Employed**
If anyone in the household is currently employed, tell us about the income. Start at question 1.	Skip to question 3.	Skip to question 4.

1. **CURRENT EMPLOYMENT**:

Person	Employer Name and Address	Gross Income (Before Taxes) per Pay Period	How Often? (weekly, biweekly, monthly)

2. Did anyone in the household leave a job in the past 90 days? ☐ Yes ☐ No
If yes, list individual(s):

3. **SELF-EMPLOYMENT**: If you have self-employment expenses, please list them in question 6.

Person	Type of Work	Gross Income (Before Taxes) per Pay Period	How Often? (weekly, biweekly, monthly)

4. **OTHER INCOME THIS MONTH**: Check all that apply. List the **monthly** amount and who receives the income.
If more than one person receives the same type of income, please use the rows marked 'Other – Type'.

Type	Y	N	Person	Amount
None				
Social Security Disability (SSDI)				
Social Security Retirement				
Social Security Survivors				
Unemployment Compensation				
Pensions				
Spousal Support				
Railroad Retirement				
Contributions from Others				
Investments				
Scholarships/Grants				
Capital Gains				
Gross Farming				
Gross Rental				
Royalties				
Other – Type:				
Other – Type:				

STEP 3

5. **YEARLY INCOME**: Complete only if anyone in the household's income changes from month to month.
If you don't expect changes to anyone in the household's monthly income, skip to question 6.

Person	Total Income This Year	Total Income Next Year

6. **EXPENSES**:
Complete if you have expenses that you incur. List all that apply. Tell us the amount and how often you must pay it.
Note: Self-employment expenses should be listed here.

Type	Y	N	Person	Amount	How Often?
Dependent Care *(Adult, Child, or Elder Care)*					
Support Expenses *(Child/Spousal Support)*					
Other – Type					
Other – Type					
Other – Type					

STEP 4 American Indian or Alaska Native Family Member(s)

1. Are you or is anyone in your household an American Indian or Alaska Native?

☐ Yes. *Please also complete APPENDIX B.* ☐ No. *Skip to STEP 5.*

STEP 5 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**
If yes, check the type of coverage and write their name(s) next to the type of coverage they have.

Type of Coverage	Individual(s) Receiving This Coverage
☐ Medicaid	
☐ Medicare	
☐ VA Health Care Programs	
☐ Peace Corps	
☐ Tricare *(Do not check if you have direct care or Line of Duty)*	

☐ Employer Insurance

Name of health insurance:	Policy Number:
Is this COBRA coverage? ☐ Yes ☐ No	Is this a retiree health plan? ☐ Yes ☐ No

☐ Other – Type:

Name of health insurance:	Policy Number:

Is this a limited-benefit plan (like a school accident policy?) ☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job**? Check yes even if the coverage is from someone else's job, such as a parent or spouse (including a parent or spouse not included on this application).
☐ Yes You will also need to complete and include **APPENDIX A**. ☐ No **Continue to STEP 6**.

STEP 6 Read and Sign This Application

- I know that I must tell the Ohio Department of Medicaid if anything changes (and is different than) what I wrote on this application. I can call **1-844-640-6446** to report any changes within 10 days. I understand that a change in my information could affect the eligibility for members of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination using any of the methods listed in the **Your Civil Rights** section on page 2.
- I authorize the Ohio Department of Medicaid to check my answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Department of Homeland Security (DHS), and others, including access to education records. If the information doesn't match, the Ohio Department of Medicaid may ask me to send more information. If the matched information would result in a denial, reduction, suspension, or other adverse effect to my benefits, I understand that I'll receive a written notice of potential adverse action and be provided with the opportunity to appeal the decision.
- I know that my information on this form will be used only to determine eligibility for health coverage and additional health programs and will be kept private as required by law.
- I know that the information provided on this application, including my phone number(s), will be shared with the county JFS offices and managed care organizations to which I'm assigned. I consent to being called or texted by the county JFS offices and managed care organizations, or any contractors acting on their behalf, at any phone number(s) I provide in relation to my application, now or in the future, including with regard to my healthcare needs and treatment, wellness services, plan benefits, eligibility, renewal and/or redetermination, and for any other communications relating to my relationship with the county JFS offices and the managed care organizations or concerning my Medicaid coverage. These calls/texts may be made using automated technology, such as with an automatic telephone dialing system or artificial or prerecorded voice message. Standard message and data rates may apply.

If anyone on this application is eligible for Medicaid

- I am giving the Ohio Department of Medicaid our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving the Ohio Department of Medicaid our rights to pursue and get medical support from an ex-spouse or parent.
- If any 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 know that I can tell Medicaid and I may not have to cooperate.
- I authorize any person who furnishes health care, medical supplies, or services to give the Ohio Department of Medicaid, the Ohio Department of Job & Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Medicaid program, WIC, and other medical assistance programs. I also authorize the previously mentioned departments to exchange any information I have provided on this form to enable the departments to determine eligibility for benefits.
- I understand that if I do not qualify for Medicaid, the Ohio Department of Medicaid may send my information to another program so they can see if I qualify.
- I understand that the Ohio Department of Medicaid will get information about my financial resources from banks, credit unions, or other financial institutions in order to determine my eligibility for medical assistance. Authorization to get this information remains in effect until:
    - My application for medical assistance is denied; or
    - My eligibility for medical assistance ends; or
    - I inform the Ohio Department of Medicaid in writing that I wish to end my authorization.
- If I refuse to authorize the Ohio Department of Medicaid to get information about me from financial institutions, or I decide to end my authorization, I understand that my medical assistance may be denied or discontinued.
- I understand that when I send in this application it means I have permission from everyone whose information is on the form to submit their information to the Ohio Department of Medicaid and receive any communications about their eligibility and enrollment.
- I understand that the Ohio Department of Medicaid is authorized to collect information on this form, and other supporting information including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.
- I understand that if I am permanently institutionalized or age 55 or older when I receive Medicaid benefits, after my death the Estate Recovery Program will seek to recover payments for the cost of my care paid by Medicaid from my estate. The cost of my care may include the capitation payments that Medicaid pays to my managed care plan, even if the capitation payments are greater than the cost of the services that I actually received.

STEP 6 Read and Sign This Application (continued)

My right to an appeal

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

Sign this application. The person listed in STEP 1 should sign this application. If you're an authorized representative, you may sign here as long as the person listed in STEP 1 signed **APPENDIX C**.

I am signing this application under penalty of perjury which means I have provided true answers to all of the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information. By signing the application, I am agreeing to all statements listed above.

☐ Check here if you are an authorized representative.
If you are an authorized representative, you may sign here as long as you have provided the information required in **APPENDIX C**.

Signature	Date (mm/dd/yyyy)

STEP 7 What To Do When You Complete This Application

Return this application to your local County Department of Job and Family Services office.
To search for your county JFS office, go to **http://jfs.ohio.gov/County/County_Directory.pdf**

To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to: oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling the Medicaid Consumer Hotline 1-800-324-8680; individuals with a hearing impairment may call TDD 7-1-1.

Spanish
Para ayudarle a comprender este aviso, se encuentran disponibles a pedido asistencia lingüística, servicios de interpretación, ayudas auxiliares y otros servicios sin costo alguno. Los servicios disponibles incluyen, entre otros: traducción oral, traducción escrita y ayudas auxiliares. Puede solicitar estos servicios o ayudas auxiliares llamando a la Línea directa para el consumidor del Departamento de Medicaid de Ohio al 1-800-324-8680; las personas con discapacidad auditiva pueden llamar al TDD 7-1-1.

Nepali
यो सूचना बुझ्न सहायता गर्न, भाषा सहायता, व्याख्या सेवा, र सहायक उपकरण तथा सेवा तपाईंको अनुरोधमा निःशुल्क रूपमा उपलब्ध छन्। उपलब्ध सेवाहरूमा मौखिक अनुवाद, लिखित अनुवाद, र सहायक उपकरणहरू समावेश छन्, तर यिनीसँग मात्र सीमित छैन। तपाईंले यी सेवाहरू र/वा सहायक सहायताहरू अनुरोध गर्न सक्नुहुन्छ; Medicaid Consumer Hotline 1-800-324-8680; मा कल गरेर; श्रवणशक्ति कमजोर भएका व्यक्तिहरूले TDD 7-1-1 मा कल गर्न सक्छन्।

Arabic

لمساعدتك في فهم هذا الإخطار، تتوفر خدمات المساعدة اللغوية وخدمات الترجمة الفورية والمساعدات الإضافية عند الطلب دون أي تكلفة. تشمل الخدمات المتاحة، على سبيل المثال لا الحصر: الترجمة الشفوية والترجمة التحريرية والمساعدات الإضافية. يمكنك طلب هذه الخدمات أو المساعدات الإضافية أوكلتيهما عن طريق الاتصال بالخط الساخن للمستهلكين التابع لـ Medicaid على الرقم التالي 1-800-324-8680؛ وبوسع الأفراد الذين يعانون من ضعف السمع الاتصال بخدمة الهاتف النصي على الرقم التالي 1-1-7.

Haitian French Creole
Pou ede w konprann avi sa a, gen asistans lengwistik, sèvis entèpretasyon, èd oksilyè ak sèvis ki disponib gratis, lè ou fè demann pou sa. Sèvis ki disponib yo gen ladan yo, men se pa sa sèlman: tradiksyon oral, tradiksyon alekri ak èd oksilyè. Ou kapab mande sèvis sa yo ak/oswa èd oksilyè lè w rele Liy Asistans pou Konsomatè Medicaid la nan 1-800-324-8680; moun ki gen pwoblèm tande yo ka rele TDD 7-1-1.

Somali
Si lagaaga caawiyo inaad fahanto ogaysiiskan, kaalmada luqadda, adeegyada tarjumaada, iyo kaalmooyinka iyo adeegyada ayaa la heli karaa marka la codsado lacag la'aan adiga. Adeegyada la heli karo waxaa ka mid ah, laakiin aan ku xaddidnayn: tarjumaada afka, turjumaadda qoran, iyo qalabyada caawinta. Waxaad codsan kartaa adeegyadan iyo/ama caawimada caawimada adiga oo wacaya markaas Khadka Tooska ah ee Macmiilka Medicaid 1-800-324-8680; Shakhsiyaadka maqalka liidata waxay wici karaan TDD 7-1-1.

Ukrainian
Щоб допомогти вам зрозуміти зміст цього повідомлення, за запитом ви можете отримати безоплатну мовну допомогу, послуги усного перекладу, а також допоміжне обладнання та додаткові послуги. Доступні послуги включають, зокрема, усний переклад, письмовий переклад і допоміжне обладнання. Ви можете замовити ці послуги та/або допоміжне обладнання, зателефонувавши на гарячу лінію клієнтів Medicaid за номером 1-800-324-8680; для людей із вадами слуху працює номер TDD 7-1-1.

Russian
Чтобы помочь вам понять смысл этого уведомления, по запросу вы можете получить бесплатную языковую помощь, услуги устного перевода, а также вспомогательное оборудование и дополнительные услуги. Доступные услуги включают, в частности, устный перевод, письменный перевод и вспомогательное оборудование. Вы можете запросить эти услуги и/или вспомогательное оборудование, позвонив на горячую линию клиентов Medicaid по номеру 1-800-324-8680; для людей с нарушениями слуха предусмотрен номер TDD 7-1-1.

Swahili
Ili kukusaidia kuelewa notisi hii, usaidizi wa lugha, huduma za ukalimani, na visaidizi na huduma za ziada zinapatikana unapoomba bila gharama kwako. Huduma zinazopatikana ni pamoja na, lakini sio tu: tafsiri ya mdomo, tafsiri ya maandishi, na visaidizi vya ziada. Unaweza kuomba huduma hizi na/au visaidizi kwa kupiga simu ya Medicaid Consumer Hotline 1-800-324-8680; watu walio na ulemavu wa kusikia wanaweza kupiga simu TDD 7-1-1.

Kinyarwanda
Kugira ngo tugufashe gusobanukirwa iri tangazo, ubufasha bujyanye n'indimi, serivisi z'ubusemuzi, n'ibikoresho na servisi bifasha abafite ubumuga mu kumva biraboneka nta kiguzi utanze iyo ubisabye. Serivisi ziboneka zikubiyemo, ariko si gusa: ubusemuzi mu mvugo, ubusemuzi mu nyandiko, n'ibikoresho bifasha abafite ubumuga mu kumva. Ushobora gusaba izi serivisi na/cyangwa ibikoresho bifasha abafite ubumuga mu kumva binyuze mu guhamagara Umurongo utishyurwa ufasha Abakiriya ba Medicaid 1-800-324-8680; abantu bafite ibibazo mu kumva bashobora guhamagara TDD 7-1-1.

French
Pour vous aider à comprendre cet avis, une assistance linguistique, des services d'interprétation et des aides et services auxiliaires sont disponibles sur demande et sans frais. Les services disponibles comprennent, sans toutefois s’y limiter, la traduction orale, la traduction écrite et les aides auxiliaires. Vous pouvez demander ces services et/ou des aides auxiliaires en appelant la Medicaid Consumer Hotline 1-800-324-8680 ; les personnes malentendantes peuvent appeler TDD 7-1-1.

Pashtu
ستاسو په دې خبرتیا د ښه درک کولو (پوهیدو) لپاره، د ژبې مرستې، د شفاهي ژباړې خدمتونه، او اضافي مرستندویه وسایل او خدمتونه ستاسو د غوښتنې پر بنسټ بې لګښته شتون لري. په شته خدماتو کې شفاهي ژباړه، په لیکلې بڼه ژباړه، او مرستندویه وسایل شامل دي، خو یوازې په دې پورې محدود نه دي. تاسو کولی شئ د دې خدماتو او/یا مرستندویه وسایلو غوښتنه د میډیکیډ (Medicaid) د پېرودونکو ځانګړې د تلیفون شمېرې 1-800-324-8680 ته زنګ وهلو له لارې وکړئ؛ هغه کسان چې د اوربدلو کمزورتیا لري کولی شي 1-1-7 TDD ته زنګ ووهي.

Dari
برای کمک به شما در درک این اطلاعیه، کمک های زبانی، خدمات ترجمه شفاهی و کمک ها و خدمات اضافی بر اساس درخواست شما بطور رایگان برای شما ارائه می گردد. خدمات موجود شامل موارد ذیل میباشد، اما محدود به آنها نیست: ترجمه شفاهی، ترجمه کتبی و وسایل کمکی. شما می‌توانید این خدمات و/یا وسایل کمکی را با تماس با خط ویژه مصرف کنندگان Medicaid از طریق شماره 1-800-324-8680 درخواست دهید؛ افراد دارای اختلال شنوایی می‌توانند با شماره 1-1-7 TDD تماس بگیرند.

Uzbek
Bu bildirishnomani tushunishingizga yordam berish uchun so‘rovingiz asosida bepul til yordamchi xizmatlari, og‘zaki tarjima xizmatlari va qo‘shimcha yordamchi vositalar taqdim etiladi. Mavjud xizmatlar qatoriga og‘zaki tarjima, yozma tarjima hamda yordamchi vositalar kiradi. Siz ushbu xizmatlar va/yoki qo‘shimcha yordamlar haqida Medicaid mijozlari uchun mo‘ljallangan 1-800-324-8680 telefon raqamiga qo‘ng‘iroq qilib so‘rashingiz mumkin; Eshitish qobiliyati cheklangan shaxslar TDD 7-1-1 raqami orqali bog‘lanishlari mumkin.

Vietnamese
Để giúp bạn hiểu thông báo này, hỗ trợ ngôn ngữ, dịch vụ phiên dịch, phương tiện trợ giúp và dịch vụ phụ trợ được cung cấp miễn phí theo yêu cầu. Các dịch vụ có sẵn bao gồm, nhưng không giới hạn ở: dịch bằng lời nói, dịch bằng văn bản và phương tiện phụ trợ. Bạn có thể yêu cầu các dịch vụ này và/hoặc phương tiện phụ trợ bằng cách gọi tớiĐường dây nóng cho Người tiêu dùng Medicaid theo số 1-800-324-8680; người khiếm thính có thể gọi TDD 7-1-1.

Tigrinya
ነዚ ምልክታ ክትርደእዎ ንኽሕግዘኩም፣ ሓገዝ ቋንቋ፣ ኣገልግሎታት ትርጉም፣ ከምኡ'ውን ተወሰኽቲ ሓገዛትን ኣገልግሎታትን ኣብ ዝሓተትክምዎ ብዘይ ክፍሊት ይርከቡ። ዘለው ኣገልግሎታት፣ ናይ ዘረባ ትርጉም፣ ናይ ጽሑፍ ትርጉምን ተወሰኽቲ ሓገዛትን ዘጠቓልሉ ኮይኖም፣ በዚ ጥራሕ ዝድረቱ ኣይኮኑን። ናብ መስመር ቴሌፎን ተጠቀምቲ ሜዲኬይድ (Medicaid Consumer Hotline) 1-800-324-8680 ብምድዋል፣ ነዞም ኣገልግሎታትን/ወይ ተወሰኽቲ ሓገዛት ክትሓቱ ትኽእሉ ኢኹም፤ ናይ ምስማዕ ጸገም ዘለዎም ውልቀ-ሰባት ናብ TDD 7-1-1 ክድውሉ ይኽእሉ እዮም።

APPENDIX A HEALTH COVERAGE FROM JOBS

You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. **Have the person who is offered the employer health insurance fill out questions 1-3 and ask the employer to fill out the rest of the form.** Attach a copy of this page for each job that offers coverage.

EMPLOYEE Information

1. Employee Name (First Name, Middle Name, Last Name)	2. Employee Social Security Number (SSN)

3. List the first and last names of each person in the employee's household and tell us if they could get health coverage through the employer named in question 4, below, even if they're not currently enrolled.

Name	Eligible for health coverage through this employer?	If yes, when can this person enroll in coverage?
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

EMPLOYER Information

Ask the employer to enter the information in questions 4-14.

4. Employer/Company Name

5. Person or Department we can contact about employee health coverage *(we may contact this person if we need more information)*

6. Employer Contact Address

7. City	8. State	9. Zip Code

10. Employer Contact Phone Number	11. Employer Identification Number (EIN)

12. Employer E-mail Address

Tell us about the health coverage offered by this employer.

13. Does the employer off a health plan that meets the minimum value standard? A health 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.

☐ **YES**. Skip to question 14. ☐ **NO**. Stop and return this form to the employee.

14. How much would the employee have to pay for the lowest cost plan offered to the employee only that meets the minimum value standard? Don't include family plans. NOTE: If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

a. Employee would pay this premium $ _____

NOTE: Enter the lowest amount the employee would pay for health coverage that meets the minimum value standard.

b. Employee would pay this amount:

☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Once a Month ☐ Quarterly ☐ Yearly

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APPENDIX B American Indian or Alaska Native (AI/AN) Family Member

Complete this appendix if you or a family member are American Indian or Alaska Native and are applying for coverage.
Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).
American Indians and Alaska Natives can get services from the Indian Health Services, 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 following questions to make sure that your family gets the most help possible.
NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First, Middle, Last, Suffix)	First Middle Last Suffix	First Middle Last Suffix
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name: _____ ☐ No	☐ Yes **If yes**, tribe name: _____ ☐ No
3. Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List 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 the Interior (including reservations and former reservations) • Money from selling things that have cultural significance.	$ _____ How Often?	$ _____ How Often?

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APPENDIX C Assistance with Completing this Application

Section 1

1. Name of Applicant/Recipient	2. Social Security Number

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application and your Medicaid benefits, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local JFS office. If you are a legally appointed representative for someone on this application, submit proof with the application.

3. Name of Authorized Representative	4. Title	5. Company/Organization

6. Mailing Address	7. Apartment or Suite Number	
8. City	9. State	10. Zip Code

11. Home Phone	12. Work Phone	13. Email Address

14. **I authorize my representative to do the following on my behalf**:

☐ Act on my behalf in all matters with the agency ("agency" includes the County Department of Job and Family Services [CDJFS], the Ohio Department of Medicaid [ODM], and ODM's contracted designees).

OR only the specific actions selected below:

☐ Assist with my application/renewal for benefits ☐ Provide verifications to the CDJFS on my behalf
☐ Represent me at a state hearing ☐ Receive and respond to copies of all correspondences
☐ Discuss and receive information regarding my financial and medical information including protected health information (PHI)*
☐ Other (*please specify*)

15. This authority lasts until (*specify a date or event*), or until it is revoked by me in writing.

***Note**: *You must complete Section* 2 *of this form if this authorization is intended to allow the use or disclosure of PHI.*

While this authorization is in effect, all notices sent by the CDJFS and/or ODM will also be sent to your authorized representative (if the authorization allows for it).

Signatures. This form has no effect unless signed by both the person granting authority and by the authorized representative. By signing below, the authorized representative agrees to maintain the confidentiality of any information regarding the applicant/recipient provided by the agency. If the authorized representative is a provider, staff member, or volunteer of an organization, then the authorized representative also agrees to adhere to the regulations cited in 42 C.F.R. 435.923(e).

16. Signature of Person Granting Authority (*Applicant/Recipient or Parent/Guardian*)		17. Date
18. Signature of Authorized Representative	19. Title (*if employee of an organization*)	20. Date

APPENDIX C Assistance with Completing this Application (continued)

Section 2

Authorization for the Use and Disclosure of Protected Health Information

1. Name of Applicant/Recipient	2. Social Security Number

The County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM), and ODM's contracted designees (including Medicaid managed care organizations) are authorized to disclose my protected health information (PHI) to my authorized representative designated in Section 1 of this form.

I hereby authorize the use or disclosure of my protected health information (PHI) as described below.
I understand PHI can include the following types of information and authorize its disclosure: medical records; substance abuse care; vision care; reproductive care; mental health; communicable disease; pharmacy; HIV/AIDS; dental records; and psychiatric care.

3. This protected health information may be disclosed:

4. The information is being released for the following purpose(s):

Terms and Conditions

By signing below, I hereby authorize the disclosure of my PHI by the agency. I understand that:

- This authorization expires on the following date or event , or upon revocation by me in writing, whichever occurs first.
- I may revoke this authorization at any time. If I revoke this authorization, the revocation is not effective for the use or for the disclosure of my information that has already occurred.
- Any information used or disclosed pursuant to this authorization could be re-disclosed by the person or entity receiving the information and will likely no longer be protected by federal privacy regulations.
- This authorization is voluntary and that I may refuse to sign it. The provision of treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- In the event my records contain psychotherapy notes, a separate authorization may be required for the release of any psychotherapy notes.
- This authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

By signing below, I confirm that I have read and understand the contents of this authorization and confirm that the contents are consistent with my direction to the entity releasing my information.

5. Signature of Applicant/Recipient	6. Date

If this form is signed by someone other than the Applicant/Recipient, please describe the authority to act on the individual's behalf (*such as Power of Attorney or Legal Guardian*). If not already on record with the agency, please provide legal documentation showing this authority.

APPENDIX D Additional Person

Complete APPENDIX D for your spouse/partner and children who live with you, and/or anyone listed on your federal income tax return if you file one. See page 6 for more information about who to include. If you don't file a tax return, remember to add all family members who live with you.

1. First Name	Middle Name	Last Name	2. Relationship to you

3. Date of birth *(mm/dd/yyyy)*	4. Sex ☐ Male ☐ Female	5. Social Security Number (SSN)

6. Does this person live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. Does this person plan to file a federal income tax return NEXT YEAR?
(This person can still apply for health insurance even if he or she doesn't file a federal income tax return.)
☐ Yes. *Please answer questions a-c.* ☐ No. *Skip to question c.*

a. Will this person file jointly with a spouse? ☐ Yes ☐ No
If yes, list name of spouse _____

b. Will this person claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will this person be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____

How is this person related to the tax filer? _____

8. Is this person married? ☐ Yes ☐ No

9. Does this person want health coverage? Even if this person has insurance, there might be a program with better coverage or lower costs. ☐ Yes. *Answer questions 10-24.* ☐ No. *Skip to the income questions in STEP 3.*

10. Does this person want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

11. Does this person have a medical condition that limits one or more daily activities (like bathing, dressing, daily chores, etc.)?
☐ Yes. *Please also complete **APPENDIX E**.* ☐ No

12. Is this person requesting in-home care or nursing home care? ☐ Yes. *Please also complete APPENDIX E.* ☐ No

13. Is this person pregnant? ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? _____ Expected due date (optional): _____

14. If not currently pregnant, was this person pregnant recently? ☐ Yes ☐ No
If yes, how many babies were expected during this pregnancy? Pregnancy End Date

15. Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No
If yes, is this person a naturalized or derived citizen? ☐ Yes ☐ No

16. If this person is not a U.S. Citizen or U.S. national, does this person have eligible immigration status?
☐ Yes. *Fill in this person's document type and ID number below.* ☐ No

Document Type:	Document ID Number:
Has this person lived in the U.S. since August 22, 1996? ☐ Yes ☐ No	Is this person, his/her spouse, or his/her parent(s) a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

17. If this person lives with at least one child under the age of 19, is he or she the main person taking care of this child?
☐ Yes ☐ No

18. Is this person going to school, in college, or in training? ☐ Yes ☐ No **If yes,** please provide the following information

Type of school: ☐ College/Higher Education ☐ Vocational ☐ GED ☐ Technical Training

Enrollment: ☐ Full Time ☐ Half Time ☐ Less than Half Time

19. Was this person in foster care at age 18 or older? ☐ Yes ☐ No

a. **If yes**, when did this person enter foster care? _____

b. When did this person leave foster care? _____

c. In which state was this person in foster care? _____

APPENDIX D **Additional Person (Continued)**

20. Is this person currently incarcerated (detained or jailed)? ☐ Yes ☐ No
If yes, please provide date of incarceration: _____ Expected date of release *(optional):* _____

21. Is this person currently or has this person ever served in the military? ☐ Yes ☐ No

22. Is this person currently receiving or has this person ever received benefits in another state? ☐ Yes ☐ No
If yes, where?

23. Is this person Hispanic or Latino? *(OPTIONAL – check all that apply)*
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

24. RACE *(OPTIONAL – check all that apply)*

☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese
☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander
☐ Other _____

APPENDIX E Medicaid for the Aged, Blind, or Disabled

You DO NOT need to answer these questions unless someone in the household is applying for Medicaid coverage because they're aged, blind, disabled, or wanting help with paying their Medicare premiums. This appendix should also be completed if someone in the household is applying for in-home care or nursing facility care.

Please read all questions carefully and complete each section to the best of your ability.
If you have any questions, please call 1-866-640-6446.

Estate Recovery

If you are permanently institutionalized or age 55 or older when you receive Medicaid benefits, after your death the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the capitation payments that Medicaid pays to your managed care plan, even if the capitation payments are greater than the cost of the services you actually received.
https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM07400.pdf

Tell us about who is applying. *(If you have additional people on this application applying for Medicaid for the Aged, Blind, or Disabled, please make a copy of APPENDIX E and attach to the application.)*

	PERSON 1	PERSON 2
1. Name (First, Middle, Last, Suffix)	First Middle Last Suffix	First Middle Last Suffix
2. Is this person currently receiving or entitled to Medicare?	☐ Yes ☐ No **If yes**, Medicare number:	☐ Yes ☐ No **If yes**, Medicare number:
3. Is this person blind?	☐ Yes ☐ No	☐ Yes ☐ No
4. Is this person requesting in-home care or nursing facility care?	☐ Yes ☐ No **If yes**, select an option below: ☐ In-home care ☐ Nursing facility care	☐ Yes ☐ No **If yes**, select an option below: ☐ In-home care ☐ Nursing facility care
5. Is this person interested in applying for the Residential State Supplement (RSS) program?	☐ Yes ☐ No	☐ Yes ☐ No

RSS is a program for low-income adults who are at least age 65 or who have disabilities. The RSS program helps with financial assistance so that individuals can live in Residential Facilities. Applicants must meet at least a Protective Level of Care in addition to other program eligibility criteria.

6. **Additional income this month**: Check all that apply. List the monthly amount and who receives the income.
If more than one person receives the same type of income, please use the rows marked 'Other – Type'.

Type	Y	N	Person	Amount
Supplemental Security Income (SSI)				
Veterans' Benefits				
Workers' Compensation				
Other – Type				
Other – Type				
Other – Type				

APPENDIX E Medicaid for the Aged, Blind, or Disabled (continued)

7. **Tell us about the resources that belong to household members**. List all that apply to the individual applying for Medicaid for the Aged, Blind, or Disabled. If the individual is married, please also list all that apply to the individual's spouse.
Tell us the account/policy number and the value for each.
If you have more than one of the items listed below, please include information regarding each additional account or policy below in response to question 8.

Type	Y	N	Person	Account/Policy Number	Value
401(k)/Keogh/IRA/Retirement Pension					
ABLE Account					
Agency Payment Card					
Annuity Account					
Burial Insurance					
Burial Space					
Cash/Uncashed Check/Uncashed Funds					
Certificate of Deposit (CD)					
Checking Account					
Continuing Care Retirement Community Entrance Fee					
Life Insurance - Term					
Life Insurance - Universal					
Life Insurance - Whole					
Long-Term Care (LTC) Insurance					
Money Market					
Mutual Fund					
Prepaid Burial Contract					
Promissory Note					
Property Agreement (Mortgage/Deed)					
Real Property Sold on Land Contract					
Savings Account					
Stocks/Bonds					
Tribal Gaming Ongoing Distributions					
Trust					
Other – Type:					

8. **Tell us about any additional accounts or policies.**
If you have multiple accounts and/or policies for the items listed above in question 7, please list the information below.

Type	Person	Account/Policy Number	Value

9. **Tell us about real property that belongs to anyone in the household**. List all that apply.

Type	Y	N	Person	Address	Fair Market Value	Date Purchased	Date Listed for Sale
Building							
Real Estate Property of Non-Citizen Sponsor							
House/Condominium							
Land							
Life Estate							
Lot – Vacant							
Lot with Buildings							
Mobile Home							

APPENDIX E Medicaid for the Aged, Blind, or Disabled (continued)

10. **Tell us about personal property that belongs to anyone in the household**. List all that apply.

Type	Y	N	Person	Date Obtained	Fair Market Value
Collectibles/Jewelry					
Crops					
Tools					
Livestock/Poultry					
Other – Type:					

11. **Tell us about any motor vehicles that belong to anyone in the household.**
(Please include all vehicles that have a household member on the registration, even if not running.)

Type	Person	Year	Make	Model	Fair Market Value

12. **Tell us about all resources listed in questions 7 through 11 that were sold, traded, or given away in the last 5 years.**

Person	Description	Fair Market Value	Date Sold, Traded, or Given Away	Amount Sold For

13. **Tell us about any additional expenses (not listed in Step 3) that you pay each month.**

Type	Y	N	Person	Amount
Medical Expenses				
Medicare Premiums				
Housing Expenses				
Utility Expenses (Gas, Electric, Water, etc.)				
Other – Type:				
Other – Type:				
Other – Type:				

Voter Registration and Information Update Form

Please read instructions carefully. Please type or print clearly with blue or black ink.
For further information, you may consult the Secretary of State's website at VoteOhio.gov or call 877-SOS-OHIO (877-767-6446).

Eligibility
You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be received or postmarked by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Numbers 1 and 2 below are required by law. You *must* answer *both* of the questions for your registration to be processed.

Please see information on back of this form to learn how to obtain an absentee ballot.

Identification Requirements
If you have a current Ohio driver license or state ID card, you must provide that number on line 10. If you do not have an Ohio driver license or state ID card, you must provide the last four digits of your Social Security number on line 10. If you have neither, please write "None."

Residency Requirements
Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

Your Signature
In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

I am: ☐ **Registering as an Ohio voter** ☐ **Updating my address** ☐ **Updating my name**

1. Are you a U.S. citizen? ☐ Yes ☐ No
2. Will you be at least 18 years of age on or before the next general election? ☐ Yes ☐ No

IF YOU ANSWERED NO TO EITHER OF THE QUESTIONS, DO NOT COMPLETE THIS FORM.

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SEC4010
Revised 03/2025

3. Last Name	First Name	Middle Name or Initial	Jr., II, etc.	City, Village, Township
4. House Number and Street (Enter new address if changed) Apt. or Lot #		5. City or Post Office	6. ZIP Code	Ward
7. Additional Mailing Address (if necessary)			8. County (where you live)	Precinct
9. Birthdate (MM/DD/YYYY) (required)	10. Ohio driver license number, state ID card number, OR last four digits of Social Security number (one form of ID required to be listed or provided)		11. Phone Number (voluntary)	School District
12. **PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION** - Previous House Number and Street				Congressional District
Previous City or Post Office		County	State	Senate District
13. **CHANGE OF NAME ONLY** Former Legal Name		Former Signature		House District

14. I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.

Your Signature ↓ **Date** (MM/DD/YYYY) _____

☐ I completed this form on behalf of the applicant due to disability, blindness, or illiteracy. I attest that the applicant indicated that he/she desired to register to vote or update the applicant's name or residence.

Signature of assister for applicant in accordance with R.C. 3503.14(C).

TO ENSURE YOUR INFORMATION IS RECEIVED, PLEASE DO THE FOLLOWING:

1. Print this form.
2. Make sure all required fields are complete.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections.

For your county board's address please visit VoteOhio.gov/Boards.

If you have additional questions, please call the
office of the Ohio Secretary of State at 877-SOS-OHIO (877-767-6446).

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

Any Ohio voter whose registration is up to date may cast an absentee ballot. Absentee ballot applications can be obtained from your county board of elections or from the Secretary of State online at VoteOhio.gov or by phone at 877-SOS-OHIO (877-767-6446).

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring photo identification to the polls in order to verify identity. Voters who do not provide identification will still be able to cast a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please visit the Secretary of State's website at VoteOhio.gov or call 877-SOS-OHIO (877-767-6446).

Please note, if the applicant's driver license or ID contains a "NONCITIZEN" identifier (on the back), the identification requires additional proof of U.S. citizenship.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.