



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process

S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

- The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

- An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

- An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

- Yes No



Medicaid Eligibility

- The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:
- Once every 12 months
 - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

- Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):
- Once every 12 months
 - Once every 6 months
 - Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

- The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



Use this application to see what you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)



Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.



Apply faster online

Apply faster online at HealthCare.gov or benefits.Ohio.gov.



What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants 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 income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, visit: <http://medicaid.ohio.gov/FOROHIOANS/AlreadyCovered/NoticeofPrivacyPractices.aspx>



What happens next?

Send your complete, signed application to your local County Department of Job & Family Services office. Find your county office here: jfs.ohio.gov/County/County_Directory.pdf
If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, call **(800) 324-8680**. Filling out this application doesn't mean you have to buy health coverage.



Get help with this application

- **Online:** HealthCare.gov or benefits.Ohio.gov
- **Phone:** Call the Medicaid Consumer Hotline at **(800) 324-8680**.
- **In person:** Contact your local County Department of Job & Family Services office.
- **En Español:** Llame a nuestro centro de ayuda gratis al **(800) 324-8680**.

STEP 1 Tell us about yourself.

(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 (Leave blank if you don't have one.)			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 email? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____			
17. What is your preferred spoken or written language (if not English)?			

18. VOTER REGISTRATION APPLICATION ATTACHED - ASSISTANCE AVAILABLE

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.

19. For which programs would you like to apply? (Please check). For information about these programs, please see Appendix D.

- | | |
|--|--|
| <input type="checkbox"/> Healthy Start & Healthy Families (Medicaid) | <input type="checkbox"/> Nutritional Program for Women, Infants & Children (WIC) |
| <input type="checkbox"/> Child & Family Health Services (CFHS) | <input type="checkbox"/> Bureau for Children with Medical Handicaps (BMHC) |
| <input type="checkbox"/> Help Me Grow | |

STEP 2 Tell us about your family.

Who do you need to include on this application? Tell us about them.

If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 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
- Anyone else under 21 who you take care of and lives with you
- Anyone else who lives with you but is temporarily absent and there is a definite plan for their return.

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage, unless you have a common child who lives with you.
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or 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 2 people in your family, you'll 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'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

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. Providing your SSN can be helpful if you don't want health coverage too since 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. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.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. If yes, please answer questions a-c. **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? Yes No

If yes, 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'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 pregnant? Yes No a. **If yes,** how many babies are expected during this pregnancy? _____

What is your expected due date? _____

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

YES. If yes, answer all the questions below.  **NO. If no,** SKIP to the income questions on page 3.  Leave the rest of this page blank.

9. Do you have any physical, mental, or emotional health condition(s) that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No

10. Are you a U.S. citizen or U.S. national? Yes No

11. **If you aren't a U.S. citizen or U.S. national,** but you have immigration documents, please provide the following:

a. Alien number _____

b. Document type _____ c. Document ID number _____

d. Have you lived in the U.S. since August 22, 1996? Yes No

e. Are you, your spouse, or your parent a veteran or an active duty member of the U.S. military? Yes No

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

13. 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

14. Are you a full-time student? Yes No

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

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

17. Race (OPTIONAL—check all that apply.)

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

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 18.

Self-employed

Skip to question 27.

Not employed

Skip to question 28.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number

(____) _____ - _____

20. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number

(____) _____ - _____

24. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

\$ _____

25. Average hours worked each WEEK

26. In the past year, did you: Change jobs Stop working Start working fewer hours None of these

27. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits, once business expenses are paid) from this self-employment will you get this month?

_____ \$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply. Tell us the amount and how often you receive it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

None

Unemployment \$ _____ How often? _____

Pensions \$ _____ How often? _____

Social Security \$ _____ How often? _____

Retirement accounts \$ _____ How often? _____

Alimony received \$ _____ How often? _____

Net farming/fishing \$ _____ How often? _____

Net rental/royalty \$ _____ How often? _____

Other income \$ _____ How often? _____

Type: _____

29. **DEDUCTIONS:** Check all that apply. Tell us the amount and how often you receive it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

Alimony paid \$ _____ How often? _____ Other deductions \$ _____ How often? _____

Student loan interest \$ _____ How often? _____ Type: _____

30. **YEARLY INCOME:** Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person. 

Your total income this year

\$ _____

Your total income next year (if you think it will be different)

\$ _____

THANKS! Please complete STEP 2: Person 2 for anyone else listed in the "Do Include" column on Page 1.

STEP 2: PERSON 2

If you have more than two people to include, use copies of Appendix E to provide information about additional people for this application.

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix _____ 2. Relationship to you _____

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.

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?

(You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a-c. **NO. If no, skip to question c.**

a. Will PERSON 2 file jointly with a spouse? Yes No

If yes, 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'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 pregnant? Yes No a. If yes, how many babies are expected during this pregnancy? _____

What is your expected due date? _____

9. Does PERSON 2 want health coverage? Even if they have insurance, there might be a program with better coverage or lower costs.

YES. If yes, answer all the questions below. 

NO. If no, SKIP to the income questions on page 5. 
Leave the rest of this page blank.

10. Does PERSON 2 have any physical, mental, or emotional health condition(s) that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No

11. Is PERSON 2 a U.S. citizen or U.S. national? Yes No

12. If PERSON 2 isn't a U.S. citizen or U.S. national, but has immigration documents, please provide the following:

a. Alien number _____

b. Document type _____ c. Document ID number _____

d. Has PERSON 2 lived in the U.S. since August 22, 1996? Yes No

e. Is PERSON 2, their spouse, or their parent a veteran or an active duty member of the U.S. military? Yes No

13. Does PERSON 2 want help paying for medical bills from the last 3 months?

Yes No

14. If PERSON 2 lives with at least one child under the age of 19, are they the main person taking care of this child?

Yes No

15. Was PERSON 2 in foster care at age 18 or older?

Yes No

Please answer the following questions if PERSON 2 is 22 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? Yes No

a. If yes, end date: _____

b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? Yes No

18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

19. Race (OPTIONAL—check all that apply.)

White

American Indian or

Filipino

Vietnamese

Guamanian or Chamorro

Black or African American

Alaska Native

Japanese

Other Asian

Samoan

Asian Indian

Korean

Native Hawaiian

Other Pacific Islander

Chinese

Other _____

Now, tell us about any income from PERSON 2 on the back. 

STEP 2: PERSON 2

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 20.

Self-employed

Skip to question 29.

Not employed

Skip to question 30.

CURRENT JOB 1:

20. Employer name and address	21. Employer phone number (____) _____ - _____
22. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
23. Average hours worked each WEEK	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address	25. Employer phone number (____) _____ - _____
26. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
27. Average hours worked each WEEK	

28. In the past year, did PERSON 2: Change jobs Stop working Start working fewer hours None of these

29. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply. Tell us the amount and how often you receive it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

<input type="checkbox"/> None					
<input type="checkbox"/> Unemployment	\$ _____	How often?	_____	<input type="checkbox"/> Net farming/fishing	\$ _____ How often? _____
<input type="checkbox"/> Pensions	\$ _____	How often?	_____	<input type="checkbox"/> Net rental/royalty	\$ _____ How often? _____
<input type="checkbox"/> Social Security	\$ _____	How often?	_____	<input type="checkbox"/> Other income	\$ _____ How often? _____
<input type="checkbox"/> Retirement accounts	\$ _____	How often?	_____	Type:	_____
<input type="checkbox"/> Alimony received	\$ _____	How often?	_____		

31. **DEDUCTIONS:** Check all that apply. Tell us the amount and how often PERSON 2 receives it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

<input type="checkbox"/> Alimony paid	\$ _____	How often?	_____	<input type="checkbox"/> Other deductions	\$ _____	How often?	_____
<input type="checkbox"/> Student loan interest	\$ _____	How often?	_____	Type:	_____		

32. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income this year \$ _____	PERSON 2's total income next year (if you think it will be different) \$ _____
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THANKS! This is all we need to know about PERSON 2.

STEP 3

American Indian or Alaska Native family member(s)

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

- If **No**, skip to Step 4.
- Yes**. If yes, please also complete Appendix B.

STEP 4

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?

YES. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. **NO**.

Medicaid _____

CHIP _____

Medicare _____

TRICARE (Don't check if you have direct care or Line of Duty)

VA health care programs _____

Peace Corps _____

Employer insurance: _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? Yes No

Is this a retiree health plan? Yes No

Other

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. If yes, you'll need to complete and include Appendix A.

NO. If no, continue to Step 5.

STEP 5

Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all 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.
- 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 **1-800-324-8680** to report any changes within 10 days. I understand that a change in my information could affect the eligibility for member(s) 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 by visiting www.hhs.gov/ocr/office/file.

Check one of the following:

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

_____ is incarcerated (detained or jailed).
(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

STEP 5

Read & sign this application: continued

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Ohio Department of Medicaid or Marketplace to use income data, including information from tax returns.

The Ohio Department of Medicaid or the Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my/our eligibility automatically for the next

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years 3 years 2 years 1 year Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? Yes No
- If yes, 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 Medicaid and I may not have to cooperate.
- I authorize any person who furnishes health care or medical supplies 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 Healthy Start, Healthy Families Medicaid program, WIC, and medical assistance programs. I also authorize the Ohio Department of Medicaid, the Ohio Department of Job & Family Services, and the Ohio Department of Health to exchange any information I have provided on this form, to enable the departments to determine my eligibility.

My right to appeal

If I think the Ohio Department of Medicaid or the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Ohio Department of Medicaid or the Health Insurance Marketplace that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Ohio Department of Medicaid at **1-800-324-8680**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
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STEP 6

Mail completed application.

Mail your complete, signed application to your local County Department of Job & Family Services office.

 Find your local office by visiting this link: jfs.ohio.gov/County/County_Directory.pdf

You can complete the voter registration form attached to this application.