

Ohio Department of Medicaid
EMPLOYEE STATEMENT FOR DETERMINATION OF MUNICIPAL TAX LIABILITY

In accordance with the directive issued in compliance with Ohio Revised Code Sec. 9.42 the following information must be furnished by each employee of the state or any of its instrumentalities

Employee Name <i>(first, middle initial, last)</i>	Employee ID	Agency MEDICAID
Residence Address	State	Zip + Four

Do you live within the municipal city limits of the address above? Yes No

If not, please identify the township, county or other city in which you reside.

Work Address	State	Zip + Four
Work County		

Employee Signature	Date
Payroll Officer	Date