

MEDICAID ELIGIBILITY REVIEW VERIFICATION REQUEST CHECKLIST

Covered Group Name	Application/Review Date	Case Number	Interview Date	2 nd Notice Date
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Conditions of eligibility must be verified before the County Department of Job and Family Services is able to determine eligibility for Medicaid in accordance with chapter 5101:1-38 of the Administrative Code. The verifications you need to provide are marked below. If you are having difficulty obtaining the verifications, please contact me immediately for assistance.

Verifications still needed	Document Needed (if applicable)
<input type="checkbox"/> Citizenship verification (original birth certificate, state ID passport, etc.) or proof of qualified alien status	_____
<input type="checkbox"/> Utility bills and receipts	_____
<input type="checkbox"/> Income verification (pay-stub, tax record, award letter, child support, unemployment, worker's compensation)	_____
<input type="checkbox"/> Rent/mortgage receipt	_____
<input type="checkbox"/> Proof of child/dependent care costs	_____
<input type="checkbox"/> Proof of child support paid for children not living with you	_____
<input type="checkbox"/> Proof of payments made for those not living with you, but claimed as a dependent for IRS purposes	_____
<input type="checkbox"/> Recent bank account statements (checking, credit union, savings, etc.)	_____
<input type="checkbox"/> Proof of cash value of stocks/bonds, certificates of deposit, life insurance, trusts, annuities, retirement account, etc.	_____
<input type="checkbox"/> Title to motor vehicles	_____
<input type="checkbox"/> Health Insurance Card - Copy of front and back	_____
<input type="checkbox"/> Medically verified pregnancy (number of fetuses)	_____
<input type="checkbox"/> Medical form(s) completed by doctor	_____
<input type="checkbox"/> Proof of family medical costs for individuals who are disabled, blind or those over 65 years of age (including prescriptions)	_____
<input type="checkbox"/> Past/Retroactive medical bills	_____
<input type="checkbox"/> Marriage Certificate	_____
<input type="checkbox"/> Other, specify:	_____
_____	_____
_____	_____

We must receive the verifications listed above by _____. If we do not have the required information or verifications by this date, your application may be denied or your current benefits terminated.

Report any change of address or contact information in the space provided below:

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Return all verifications in the envelope provided or send to the address, e-mail, or fax number listed below:

Address	City	State	Zip
		Ohio	
E-Mail	Fax Number		
Name of Caseworker	Date	District	Telephone Number