Ohio Department of Medicaid

Application for Health Coverage & Help Paying Costs

ODM07216 (Rev.6/2025)

THINGS TO KNOW

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: https://medicaid.ohio.gov/wps/portal/gov/medicaid/families-and-individuals/coverage/already-covered/rights/notice-of-privacy-practices

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.**

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov** or **benefits.Ohio.gov** or call us at **(800) 324-8680**. Para obtener una copia de este formulario en Español, llame **(800) 324-8680**. If you need help in a language other than English, call **(800) 324-8680** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(800) 292-3572**.

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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? ☐ Yes ☐ 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.

☐ Healthy Start & Healthy Families (Medicaid)
☐ Child & Family Health Services (CFHS)
☐ Help Me Grow
☐ Nutritional Program for Women, Infants & Children (WIC)
☐ Bureau for Children with Medical Handicaps (BCMH)

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
☐ 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 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?
☐ Student loan interest $ How often?
☐ Other deductions $ 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
☐ 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 _____

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) ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐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) ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐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).

☐ 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:

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.

☐ Alimony paid $ How often?
☐ Student loan interest $ How often?
☐ Other deductions $ 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)
$

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)

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.

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 أو كلتيهما 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 7-1-1.

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 پې 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 پیرودونکو 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።

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APPENDIX A

Ohio Department of Medicaid
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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. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last, Suffix)	2. Employee Social Security number _____-_____-_____

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) _____-_____
5. Employer address	6. Employer phone number (_____) _____-_____

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) (_____) _____-_____	12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

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EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last, Suffix)	2. Social Security Number _____- _____- _____

EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) _____- _____
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( ) –	12. Email address

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

APPENDIX B

Ohio Department of Medicaid
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American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. 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 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 name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name _____ ☐ No	☐ Yes If yes, tribe name _____ ☐ No
3. Has this person ever gotten 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, tribal health programs, or urban Indian health programs, 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, tribal health programs, or urban Indian health programs, 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 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

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, 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 County Department of Job and Family Services. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name, Suffix)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

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APPENDIX D

HEALTH COVERAGE PROGRAMS

Ohio offers families a variety of options for getting health care services. Below is a brief description of four publicly funded programs that are available throughout Ohio. Families can apply for one or all of the following programs by using the attached application.

Healthy Start and Healthy Families

The Healthy Start and Healthy Families programs offer free or low-cost health coverage to families, children (up to age 19) and pregnant women. Certain young adults meeting specific criteria may be covered up to age 21.

Coverage 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 your family needs to stay healthy and strong. Healthy Start and Healthy Families are Medicaid programs administered by the Ohio Department of Medicaid. For more information, please call 1-800-324-8680 or visit **medicaid.ohio.gov**.

Women, Infants & Children (WIC)

The Women, Infants, and Children (WIC) program provides nutritious foods, important nutrition information, and breastfeeding education and support. It also helps eligible families find health care or other services they need. 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 or visit your local WIC clinic. The WIC program is administered by the Ohio Department of Health.

Child & Family Health Services (CFHS)

The Child and Family Health Services (CFHS) program in your area may provide one or more of the following services: child and adolescent health care and prenatal care. Clinics offer physicals, nutrition counseling, social services, laboratory tests, health education and more. The cost of the clinic services is based on your family size and income but no one is turned away from services if they cannot pay. To apply, please complete the attached application or visit your local CFHS. This program is administered by the Ohio Department of Health.

Children with Medical Handicaps (BCMH)

The Children with Medical Handicaps program (BCMH) is a health care program providing services for children with special health care needs. To receive BCMH services, a child must be an Ohio resident younger than age 21 and be under the care of a BCMH-approved doctor. Families must also meet income eligibility criteria. BCMH works closely with public health nurses in local health departments to identify and coordinate services for children with medically handicapping conditions and their families. For more information, families can contact their local health department or call (800) 755 - GROW (4769). This program is administered by the Ohio Department of Health.

Help Me Grow (HMG)

The Help Me Grow Home Visiting program provides parenting education for pregnant women and first time mothers. 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 disabilities. Services are coordinated and families are connected to services which build the parent's ability to enhance their child's development so that children with disabilities or delays in development start school healthy and ready to learn.

Those who are interested in getting cash assistance through Ohio Works First or getting Food Assistance should contact their local County Department of Job & Family Services.

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APPENDIX E

Ohio Department of Medicaid
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STEP 2 ADDITIONAL PERSON _____ (give this person a number)

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 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?**
(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 this person file jointly with a spouse? ☐ Yes ☐ No

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

What is the expected due date? _____

9. **Does this person 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 this person 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 this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If this person 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 this person lived in the U.S. since August 22, 1996? ☐ Yes ☐ No

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

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

14. If this person 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 this person in foster care at age 18 or older?
☐ Yes ☐ No

Please answer the following questions if this person is 22 or younger:

16. Did this person 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
☐ 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 _____

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

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STEP 2 ADDITIONAL PERSON _____

Current Job & Income Information

☐ **Employed**
If this person is currently employed, tell us about their 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) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If this person has 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) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did this person:** ☐ 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 this person get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply. Tell us the amount and how often this person receives 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: _____

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

If this person 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.

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions $ _____ How often? _____
Type: _____

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

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

This person's total income **this year:**

$ _____

This person's total income **next year** (if you think it will be different):

$ _____

THANKS! This is all we need to know about this ADDITIONAL PERSON.

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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.

FOR BOARD USE ONLY
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.

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