Ohio Department of Medicaid

MEDICAID ELIGIBILITY REVIEW VERIFICATION REQUEST CHECKLIST

Covered Group Name	Application/Review Date	Case Number	2nd Notice Date

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 5160:1-2 of the Ohio 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)*
☐ Citizenship verification *(original birth certificate, state ID passport, etc.)* or proof of qualified alien status	
☐ Utility bills and receipts	
☐ Income verification *(pay-stub, tax record, award letter, child support, unemployment, worker's compensation)*	
☐ Rent/mortgage receipt	
☐ Proof of child/dependent care costs	
☐ Proof of child support paid for children not living with you	
☐ Proof of payments made for those not living with you, but claimed as a dependent for IRS purposes	
☐ Recent bank account statements (checking, credit union, savings, etc.)	
☐ Prof of cash value of stock/bonds, certificates of deposits, life insurance, trust, annuities, retirement account, etc.	
☐ Title to motor vehicles	
☐ Health Insurance Card - Copy of front and back	
☐ Medically verified pregnancy (number of fetuses)	
☐ Medical form(s) completed by doctor	
☐ Proof of family medical costs for individuals who are disabled, blind or those over 65 years of age *(including prescriptions)*	
☐ Past/Retroactive medical bills	
☐ Marriage Certificate	
☐ 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:

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

Address	City	State **Ohio**	Zip

E-Mail	Fax Number

Name of Caseworker	Date	District	Telephone Number