Ohio Department of Medicaid
QUALIFIED INCOME TRUST VERIFICATION

INDIVIDUAL INFORMATION		
Individual Name *(Last, First, MI)*	**Date of Birth** *(mm/dd/yyyy)*	
Medicaid ID Number *(12 digits)*	**Case Number**	
Individual Street Address	**Apt/Unit Number**	
City	**Zip Code**	**County**

TRUST INFORMATION		
Name of Trustee *(Last, First, MI)*	**Date Trust Established** *(mm/dd/yyyy)*	
Name of Location where Trust Account Established		
Street Address	**Building/Unit Number**	
City	**State**	**Zip Code**
Account Name	**Account Number**	
Account Contact Name	**Account Contact Phone Number**	

Source of Income *(select all that apply)*

☐ Social Security
  Amount:
☐ Veteran Benefit (VA Pension)
  Amount:
☐ Railroad Retirement
  Amount:

☐ Company Retirement
  Company Name:
  Amount:
☐ Other *(specify source):*
  Amount:

Amount to be Deposited into Trust	**Effective Date of Deposit** *(mm/dd/yyyy)*	**Monthly Account Maintenance Fee**
Trustee Signature	**Date** *(mm/dd/yyyy)*	

Completed document should be submitted to the local county department of job and family services (CDJFS). Contact information for the CDJFS can be found at http://jfs.ohio.gov/County/County_Directory.pdf

If the monthly account maintenance fee is higher than the approved amount, please submit this form to medicaid_eligibility_ta@medicaid.ohio.gov.

FOR ODM USE ONLY:	
Has an exception to allow the higher account maintenance fee been approved by ODM? ☐ Yes ☐ No	
Approved By	**Date Exception Approved** *(mm/dd/yyyy)*

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