Ohio Department of Medicaid

Affidavit of Child Caregiver

This affidavit is to be completed and signed by the child caregiver who provided care to an institutionalized parent which permitted that parent to reside at home rather than in a long-term care facility (LTCF) or be enrolled on a Medicaid Home and Community-Based Services (HCBS) waiver. Completing this form does not mean that the transfer of your parent's home to you was proper as defined in Ohio Administrative Code 5160:1-6-06. The burden is on the Medicaid applicant or recipient to show that the transfer of a home, in accordance with OAC 5160:1-6-06(D)(2), is proper. The Agency may request additional information from you, your parent, your parent's physician, or another qualified medical professional to determine whether the requirements in OAC 5160:1-6-06(D)(2) are met. This affidavit will not be used to determine the amount, duration, or scope of services that your parent needs.

Information and Instructions for completing this form:

Use black or blue ink when completing this form
Type or write legibly
Include your name or initials on each page of any attached documentation
If additional space is necessary, you may attach additional pages
Have the form notarized in the Acknowledgment Box
Return this form, along with supporting documentation to the Medicaid applicant/recipients local County Department of Job and Family Services

Information about Individual Transferring the Home		
First Name	Last Name	Medicaid Case Number
Current Address of Individual Transferring the Home *(No PO Box)*		
City	State	Zip Code

Child Caregiver's Information		
Child Caregiver's First Name	Child Caregiver's Last Name	Date of Birth *(mm/dd/yyyy)*
Child Caregiver's Current Address *(No PO Box)*		
City	State	Zip Code
County	Child Caregiver's Phone Number	
Date Child Caregiver moved into current address		
If Child Caregiver has Medicaid, please provide Medicaid Case Number		

You may be asked to provide proof of address. If so, please provide at least two (2) of the following types of documentation to show your continued residence at the address listed above:

Valid Driver's license
Valid State Identification Card
Utility Bill
Voter Registration Card
Posted mail with name of caregiver child

Did you reside in your parent's home for ***at least two years*** immediately preceding his or her admission to a facility or enrollment on a Medicaid home and community-based services (HCBS) waiver and provide care that delayed that admission or enrollment?	☐ Yes ☐ No
If no, please explain	
Are you the biological or adopted child of the individual transferring the home? *(Note: A birth certificate may be requested by the agency to verify parentage.)*	☐ Yes ☐ No

Information about Care you Provided to your Parent

For the time period immediately preceding your parents' admission to an institution or enrollment on a Medicaid HCBS waiver, please explain how the care you provided to your parent prevented him or her from needing such institutionalization or a Medicaid HCBS waiver. Include services that you or someone else provided, including the type of service provided, the frequency with which it was provided, the duration of service provided, and who provided the service:

Please attach supporting documentation. Supporting documentation may include letters from your parents' medical providers, medical records, receipts and/or bills for medical or personal care services provided to your parent.

Service type examples:
Assisting with bathing, toileting, dressing
Shopping, preparing meals
Assisting with tube feeding, providing injections or wound/skin ulcer care
Medication administration

Information about Care you Provided to your Parent			
Service Provided	Frequency (i.e. daily, monthly)	Duration (in years and months)	Provider (i.e. self, independent service provider)

I swear that I am the child caregiver who completed this affidavit. I swear that the information on this affidavit and any information on any attached documents that I provided are true and accurate to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability or may subject my parent to an overpayment of Medicaid benefits or a period of restricted Medicaid coverage in accordance with Ohio Administrative Code Chapter 5160:1-6.

_____ _____

Printed Full Name of Child Caregiver Date Signed *(mm/dd/yyyy)*

_____

Signature of Child Caregiver

Acknowledgment

State of _____ County of _____

The foregoing instrument was subscribed and sworn to before me this _____day of _____, 20_____,

by _____.

Personally Known to Me: _____ OR Type of Identification Produced:

_____

Notary Public's Signature: _____

My Commission Expires:_____

SEAL/STAMP: