

Records / Submission Packages - Your State

OH - Submission Package - OH2025MS0001O - (OH-25-0008) - Eligibility

VIEW PRINT PREVIEW

Summary Reviewable Units Versions Correspondence Log Approval Letter RAI News Related Actions

← All Reviewable Units
← Submission - Tribal Input

Medicaid State Plan Eligibility

General Eligibility Requirements

Application

MEDICAID | Medicaid State Plan | Eligibility | OH2025MS0001O | OH-25-0008

📄 Spell Check Instructions | 🛠 Request System Help

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	OH2025MS0001O	SPA ID	OH-25-0008
Submission Type	Official	Initial Submission Date	4/25/2025
Approval Date	10/24/2025	Effective Date	4/1/2025
Superseded SPA ID	OH-13-0026, MMDL form S94 User-Entered		

View Implementation Guide

VIEW ALL RESPONSES

A. MAGI Paper Application

Collapse

The state uses the following paper application(s) for individuals applying for coverage based on the applicable modified adjusted gross income (MAGI) standard.

- ☒ 1. The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act
- ☐ 2. One or more alternative single, streamlined applications developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary
- ☐ 3. One or more alternative applications used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs
- ☐ 4. Other alternative applications, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

B. MAGI Online Application

Collapse

The state uses the following online application(s) for individuals applying for coverage based on the applicable MAGI standard.

- ☒ 1. The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act
- ☐ 2. One or more alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary
- ☐ 3. One or more alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single application used only for insurance affordability programs to individuals seeking assistance only through such programs
- ☐ 4. Other alternative applications, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

C. Basis Other than MAGI - Paper Application

Collapse

The state uses the following paper application(s) for individuals applying for coverage on a basis other than the applicable MAGI standard:

- ☐ 1. The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary

The supplemental form(s) used to collect additional information has been uploaded.

Name	Date Created	
ODM 07216	8/1/2025 2:54 PM EDT	

- ☐ 2. One or more applications designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary
- ☐ 3. One or more applications used to apply for multiple human service programs
- ☐ 4. Other alternative applications

D. Other than MAGI - Online Application

Collapse

The state uses the following online application(s) for individuals applying for coverage who may be eligible on a basis other than the applicable MAGI standard:

- ☐ 1. The single, streamlined application developed by the Secretary or one of the alternate online forms developed by the state and approved by the Secretary, and supplemental online forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary

Screenshots or other documentation of the online form(s) used to the collect additional information have been uploaded

Name	Date Created	
Online Application Screen Shots	4/8/2025 10:05 AM EDT	

- ☐ 2. One or more application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary
- ☐ 3. One or more application used to apply for multiple human service programs
- ☐ 4. Other alternative applications

E. Additional Information (optional)

Collapse

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Application for Health Coverage & Help Paying Costs

Apply faster online

Apply faster online at benefits.ohio.gov or [Healthcare.gov](https://healthcare.gov).

Use this application to see what you qualify for

- Free or low-cost insurance from Medicaid for adults and children
 - Help with paying Medicare-related costs such as monthly premiums
 - Affordable private health insurance plans that offer full coverage to help you stay well. Filling out this application does not mean you have to buy health coverage.
 - A tax credit that can help pay your premiums for private health coverage
-

Who can use this application?

- Use this application to apply for anyone in your family.
 - Apply even if you, your spouse, or your child already have health coverage. You could be eligible for lower-cost or free coverage.
 - Families that include non-citizens can apply. You can apply for your child even if you're not eligible for coverage. Applying will not affect your U.S. citizenship status or chances of becoming a permanent resident or citizen.
 - If someone is helping you fill out this application, you may need to fill out APPENDIX C.
-

What you may need to apply

- Social Security Numbers (or document numbers for any qualified non-citizens 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 your income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law.**

ODM may use or disclose member information consistent with the notice of privacy practices, available on the ODM website.

To view the ODM Notice of Privacy Practices, 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 completed, signed application to your local county JFS office.

Find your county office here: <https://jfs.ohio.gov/about/local-agencies-directory>

If you do not have all the information we ask for, sign and submit your application anyway.

If you do not hear from us within 45 days, you may call **1-844-640-OHIO (6446)**.

Get help with this application

- **Online:** benefits.ohio.gov or [Healthcare.gov](https://healthcare.gov)
- **Phone:** **1-844-640-OHIO (6446)** or TTY **1-800-292-3572**
- **In Person:** Contact your local county JFS office
- **En Español:** **1-844-640-OHIO (6446)**

To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to: oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling the Medicaid Consumer Hotline 1-800-324-8680; individuals with a hearing impairment may call TDD 7-1-1.

Medicaid Estate Recovery

If you're permanently institutionalized or age 55 or older when you receive Medicaid benefits, after your death the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the capitation payments that Medicaid pays to your managed care plan, even if the capitation payments are greater than the cost of the services you actually received.

<https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM07400.pdf>

Your Civil Rights

The Ohio Department of Medicaid (ODM) complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, race, color, religion, sex, national origin, ancestry, disability, veteran status, sexual orientation, military status, or genetic information. Individuals eligible for, receiving services from, or benefiting from programs funded through the Ohio Department of Medicaid are protected by law against unlawful discrimination.

ODM:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Ohio Department of Medicaid's consumer hotline at [800-324-8680](tel:800-324-8680).

If you believe that ODM has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Civil Rights Coordinator

P.O. Box 182709

Columbus, Ohio 43218-2709

[614-995-9981](tel:614-995-9981)/TTY 711, Fax 1-614-644-1434

Email: ODM_EEO_EmployeeRelations@medicaid.ohio.gov.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW.

Room 509F, HHH Building

Washington, DC 20201

[800-368-1019](tel:800-368-1019), (TDD: [800-537-7697](tel:800-537-7697)).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Register to Vote

Would you like to register to vote? If yes, a Voter Registration and Information Update Form is included with this application. If you would like to register to vote, you may fill out the form and mail it to the Ohio Secretary of State at the address below. You may also fill out the form online: <https://olvr.ohiosos.gov>. Or you may download an electronic copy of the form: <https://www.sos.state.oh.us/publications/#vrf>.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. You may contact the toll-free Help Desk (1-844-640-OHIO) or the Ohio Secretary of State's toll-free number (1-877-SOS-OHIO/1-877-767-6446). You may also call or visit your local county JFS office. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you have not received any verification of your voter registration from the county board of elections in which you reside within 21 days from the date you registered, you may inquire about the status of your registration by contacting your county board of elections.

If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the prosecuting attorney or with the Secretary of State:

Ohio Secretary of State
180 E. Broad Street
Columbus, OH 43215
(614) 466-2585
Toll Free: (877) 868-3874

To locate your county prosecutor's contact information, you may review a roster of county prosecutors online at <http://www.ohiopa.org/roster.html> or you can call the Ohio Prosecuting Attorneys Association at (614) 221-1266.

HEALTH COVERAGE PROGRAMS

Ohio has several types of health care services. Below is a short description of health coverage programs that are available in Ohio. Families can apply for one or all of the following programs using the attached application.

Medicaid for Adults, Children, or Families

The Medicaid for Adults, Children, or Families program provides health care coverage that 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 you and your family need to stay healthy and strong. For more information, please call 1-800-324-8680 or visit [Medicaid.ohio.gov](https://medicaid.ohio.gov).

Medicaid for the Aged, Blind, or Disabled

The Medicaid for the Aged, Blind, or Disabled (ABD) program provides health care coverage that includes primary and acute-care benefit packages for older adults and people with disabilities. To qualify for ABD Medicaid, applicants must be: age 65 or older; or considered legally blind; or an individual with a disability (as classified by the Social Security Administration); and must meet basic requirements. For more information, please call 1-800-324-8680 or visit [Medicaid.ohio.gov](https://medicaid.ohio.gov).

Long-Term Care

Long-term services and supports are programs or services that help older adults and people with disabilities complete everyday tasks. These tasks may include bathing, getting dressed, fixing meals, and managing a home. Long-term services and supports allow individuals to live healthy, secure, and independent lives either in a long-term care facility or in a home and community-based setting. For more information, please call 1-800-324-8680 or visit [Medicaid.ohio.gov](https://medicaid.ohio.gov).

Medicare Premium Assistance Programs

The Medicare Premium Assistance Programs (MPAP) help people who are eligible for Medicare and have limited income or assets get help with paying their Medicare premiums, deductibles, co-pays, and/or coinsurance. For more information, please call 1-800-324-8680 or visit [Medicaid.ohio.gov](https://medicaid.ohio.gov).

ADDITIONAL HEALTH COVERAGE PROGRAMS

Help Me Grow (HMG)

The Help Me Grow Home Visiting program provides parenting education for pregnant women and new parents. 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 delays or disabilities. Services are coordinated and families are connected to services which build the parents' ability to enhance their child's development so that children with disabilities or delays in development start school healthy and ready to learn. For more information, visit <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/help-me-grow/help-me-grow> or call 1-800-755-GROW (4769). Help Me Grow programs are managed by the Ohio Department of Health.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC helps income eligible pregnant and breastfeeding women, women who recently had a baby, infants, and children up to five years of age who are at health risk due to inadequate nutrition. 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; visit your local WIC clinic; visit <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/women-infants-children/resources/women-infants-children-description>; or call 1-800-755-GROW (4769). The WIC program is managed by the Ohio Department of Health.

STEP 1**Tell us about yourself (the applicant)**

Complete this section for you or for the person for whom you are applying. 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

☐ Check here if you are Homeless

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 e-mail? ☐ Yes ☐ No

E-mail address:

17. What is your preferred spoken or written language (if not English)?

18. VOTER REGISTRATION APPLICATION ATTACHED

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.

Applying to register or declining to register to vote will not affect the amount of assistance that you'll be provided by this agency.

19. For which health coverage programs would you like to apply?

For information about these programs, please see Page 4.

☐ Medicaid for Adults, Children, or Families

☐ Medicaid for the Aged, Blind, or Disabled

(Also complete **APPENDIX E**)

☐ Long-Term Care (Also complete **APPENDIX E**)

☐ Medicare Premium Assistance Programs

(Also complete **APPENDIX E**)

20. For which additional programs would you like to apply?

For information about these programs, please see Page 4.

☐ Help Me Grow (HMG)

☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

STEP 2**Who do you need to include on this application?**

Do include	
Yourself	Your spouse
Your children under age 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 (you don't need to file taxes to get health coverage)	Anyone else under age 21 who you take care of and who lives with you.
Anyone else who lives with you, but is temporarily absent and there is a definite plan for their return	

You DO NOT have to include	
Your unmarried partner who doesn't need health coverage, unless you have a common child who lives with you	Your parents who live with you, but file their own tax returns (if you are over age 21)
Your unmarried partner's children	Other adult relatives who file their own tax returns

The amount of assistance or the 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 two people in your family, you will 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 will use personal information only to check if you're eligible for health coverage.

STEP 2: Person 1**Start with yourself**

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. Even if you don't want health coverage, providing your SSN is helpful because 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. For help with getting an SSN, call 1-800-772-1213 or visit ssa.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.** Please answer questions a-c. ☐ **NO.** Skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No If yes, list 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 else'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 married? ☐ Yes ☐ No

8. **Do you want health coverage?** Even if you have insurance, there might be a program with better coverage or lower costs.

☐ **YES.** Answer questions 9-23. ☐ **NO.** Skip to the income questions in STEP 3.

9. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

STEP 2: Person 1 (Continue with PERSON 1)

10. Do you have a medical condition that limits one or more daily activities (like bathing, dressing, daily chores, etc.)?

☐ **YES.** Please also complete **APPENDIX E.** ☐ **NO.**

11. Are you requesting in-home care or nursing home care?

☐ **YES.** Please also complete **APPENDIX E.** ☐ **NO.**

12. Are you pregnant? ☐ Yes ☐ No

a. **If yes,** how many babies are expected during this pregnancy?

Expected due date (*optional*):

13. If not currently pregnant, were you pregnant recently? ☐ Yes ☐ No

a. **If yes,** how many babies were expected during that pregnancy?

Pregnancy end date:

14. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, are you a naturalized or derived citizen? ☐ Yes ☐ No

15. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status?

☐ **YES.** Fill in your document type and ID number below. ☐ No

Document Type:

Document ID Number:

Have you lived in the U.S. since August 22, 1996? ☐ Yes ☐ No

Are you, your spouse, or your parent(s) a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16. 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

17. Are you going to school, college, or in training? ☐ Yes ☐ No

If yes, please provide the following information.

Type of school: ☐ College/Higher Education ☐ Vocational ☐ GED ☐ Technical Training

Enrollment: ☐ Full Time ☐ Half Time ☐ Less than Half Time

18. Were you in foster care at age 18 or older? ☐ Yes ☐ No

a. **If yes,** when did you enter foster care?

b. When did you leave foster care?

c. In which state were you in foster care?

19. Are you currently incarcerated (detained or jailed)? ☐ Yes ☐ No

If yes, please provide date of incarceration:

Expected date of release (*optional*):

20. Are you currently or have you ever served in the military? ☐ Yes ☐ No

21. Are you currently or did you previously receive benefits in another state? ☐ Yes ☐ No If yes, where?

22. Are you Hispanic or Latino? (OPTIONAL – check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

23. RACE (OPTIONAL – check all that apply)

☐ White

☐ American Indian or
Alaska Native

☐ Filipino

☐ Vietnamese

☐ Guamanian or Chamorro

☐ Black or African
American

☐ Asian Indian

☐ Japanese

☐ Other Asian

☐ Samoan

☐ Korean

☐ Native Hawaiian

☐ Other Pacific Islander

☐ Chinese

☐ Other _____

STEP 2: Person 2

Complete STEP 2 for your spouse/partner and children who live with you, and/or anyone listed on your federal income tax return if you file one. See page 6 for more information about who to include. If you don't file a tax return, remember to add all family members who live with you.

1. First Name, Middle Name, Last Name		2. Relationship to you
3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female	
5. Social Security Number (SSN)		

We need this if PERSON 2 wants health coverage and has 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?

(PERSON 2 can still apply for health insurance even if he or she doesn't file a federal income tax return.)

☐ **YES.** Please answer questions a-c. ☐ **NO.** Skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No If yes, list 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 else'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 married? ☐ Yes ☐ No

9. **Does PERSON 2 want health coverage?** Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.

☐ **YES.** Answer questions 10-24. ☐ **NO.** Skip to the income questions in STEP 3.

10. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

11. Does PERSON 2 have a medical condition that limits one or more daily activities (like bathing, dressing, daily chores, etc.)?

☐ **YES.** Please also complete **APPENDIX E.** ☐ **NO.**

12. Is PERSON 2 requesting in-home care or nursing home care?

☐ **YES.** Please also complete **APPENDIX E.** ☐ **NO.**

13. Is PERSON 2 pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected during this pregnancy?

Expected due date (optional):

14. If not currently pregnant, was PERSON 2 pregnant recently? ☐ Yes ☐ No

b. If yes, how many babies were expected during that pregnancy?

Pregnancy end date:

15. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, is PERSON 2 a naturalized or derived citizen? ☐ Yes ☐ No

16. **If PERSON 2 is not a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ **YES.** Fill in PERSON 2's document type and ID number below. ☐ No

Document Type:

Document ID Number:

Has PERSON 2 lived in the U.S. since August 22, 1996?

☐ Yes ☐ No

Is PERSON 2, his/her spouse, or his/her parent(s) a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

17. If PERSON 2 lives with at least one child under the age of 19, is he or she the main person taking care of this child?

☐ Yes ☐ No

STEP 2: Person 2**(Continue with PERSON 2)**

18. Is PERSON 2 going to school, in college, or in training? ☐ Yes ☐ No

If yes, please provide the following information:

Type of school: ☐ College/Higher Education ☐ Vocational ☐ GED ☐ Technical Training

Enrollment: ☐ Full Time ☐ Half Time ☐ Less than Half Time

19. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

a. **If yes**, when did PERSON 2 enter foster care?

b. When did PERSON 2 leave foster care?

c. In which state was PERSON 2 in foster care?

20. Is PERSON 2 currently incarcerated (detained or jailed)? ☐ Yes ☐ No

If yes, please provide date of incarceration:

Expected date of release (*optional*):

21. Is PERSON 2 currently or has PERSON 2 ever served in the military? ☐ Yes ☐ No

22. Is PERSON 2 currently receiving or has PERSON ever received benefits in another state? ☐ Yes ☐ No If yes, where?

23. Is PERSON 2 Hispanic or Latino? (OPTIONAL – check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

24. RACE (OPTIONAL – check all that apply)

☐ White	☐ American Indian or	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African	☐ or Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
☐ American	☐ Asian Indian	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
	☐ Chinese			☐ Other _____

STEP 3**Current Job & Income Information for All Household Members**☐ **Employed**

If anyone in the household is currently employed, tell us about the income.
Start at question 1.

☐ **Self-Employed**

Skip to question 3.

☐ **Not Employed**

Skip to question 4.

1. CURRENT EMPLOYMENT:

Person	Employer Name and Address	Gross Income (Before Taxes) per Pay Period	How Often? (weekly, biweekly, monthly)

2. Did anyone in the household leave a job in the past 90 days? ☐ Yes ☐ No

If yes, list individual(s):

3. SELF-EMPLOYMENT: If you have self-employment expenses, please list them in question 7.

Person	Type of Work	Gross Income (Before Taxes) per Pay Period	How Often? (weekly, biweekly, monthly)

4. OTHER INCOME THIS MONTH: Check all that apply. List the monthly amount and who receives the income.

If more than one person receives the same type of income, please use the rows marked 'Other - Type'.

Type	Y	N	Person	Amount
None				
Social Security Disability (SSDI)				
Social Security Retirement				
Social Security Survivors				
Unemployment Compensation				
Pensions				
Spousal Support				
Railroad Retirement				
Contributions from Others				
Investments				
Scholarships/Grants				
Capital Gains				
Gross Farming				
Gross Rental				
Royalties				
Other - Type:				
Other - Type:				

STEP 3

5. **YEARLY INCOME:** Complete only if anyone in the household’s income changes from month to month.
If you don’t expect changes to anyone in the household’s monthly income, skip to question 6.

Person	Total Income This Year	Total Income Next Year

6. **EXPENSES:** Complete if you have expenses that you incur. List all that apply. Tell us the amount and how often you must pay it.
Note: Self-employment expenses should be listed here.

Type	Y	N	Person	Amount	How Often?
Dependent Care (Adult, Child, or Elder Care)					
Support Expenses (Child/Spousal Support)					
Other – Type:					
Other – Type:					
Other – Type:					
Other – Type:					
Other – Type:					
Other – Type:					
Other – Type:					

STEP 4**American Indian or Alaska Native Family Member(s)****1. Are you or is anyone in your household an American Indian or Alaska Native?**

- ☐ **YES.** Please also complete **APPENDIX B.**
- ☐ **NO.** Skip to **STEP 5.**

STEP 5**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?

If yes, check the type of coverage and write their name(s) next to the type of coverage they have.

Type of Coverage	Individual(s) Receiving This Coverage		
☐ Medicaid			
☐ Medicare			
☐ VA Health Care Programs			
☐ Peace Corps			
☐ Tricare (Do not check if you have direct care or Line of Duty)			
☐ Employer Insurance			
	Name of health insurance:	Policy Number:	Is this COBRA coverage? ☐ Yes ☐ No Is this a retiree health plan? ☐ Yes ☐ No
☐ Other – Type:			
	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.** You will also need to complete and include **APPENDIX A.**
- ☐ **NO.** Continue to **STEP 6.**

STEP 6**Read and Sign This Application**

- 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 **1-844-640-6446** to report any changes within 10 days. I understand that a change in my information could affect the eligibility for members 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 using any of the methods listed in the **Your Civil Rights** section on page 2.
- I know that the Ohio Department of Medicaid will check my answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Department of Homeland Security (DHS), and others. If the information doesn't match, the Ohio Department of Medicaid may ask me to send more information. If the matched information would result in a denial, reduction, suspension, or other adverse effect to my benefits, I understand that I'll receive a written notice of potential adverse action and be provided with the opportunity to appeal the decision.
- I know that my information on this form will be used only to determine eligibility for health coverage and additional health programs and will be kept private as required by law.
- I know that the information provided on this application, including my phone number(s), will be shared with the county JFS offices and managed care organizations to which I'm assigned. I consent to being called or texted by the county JFS offices and managed care organizations, or any contractors acting on their behalf, at any phone number(s) I provide in relation to my application, now or in the future, including with regard to my healthcare needs and treatment, wellness services, plan benefits, eligibility, renewal and/or redetermination, and for any other communications relating to my relationship with the county JFS offices and the managed care organizations or concerning my Medicaid coverage. These calls/texts may be made using automated technology, such as with an automatic telephone dialing system or artificial or prerecorded voice message. Standard message and data rates may apply.

STEP 6

Read and Sign This Application (continued)

If anyone on this application is eligible for Medicaid

- I am giving the Ohio Department of Medicaid our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving the Ohio Department of Medicaid our rights to pursue and get medical support from an ex-spouse or parent.
- If any child on this application has a parent living outside of the home, 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 know that I can tell Medicaid and I may not have to cooperate.
- I authorize any person who furnishes health care, medical supplies, or services 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 Medicaid program, WIC, and other medical assistance programs. I also authorize the previously mentioned departments to exchange any information I have provided on this form to enable the departments to determine eligibility for benefits.
- I understand that if I do not qualify for Medicaid, the Ohio Department of Medicaid may send my information to another program so they can see if I qualify.
- I understand that the Ohio Department of Medicaid will get information about my financial resources from banks, credit unions, or other financial institutions in order to determine my eligibility for medical assistance. Authorization to get this information remains in effect until:
 - My application for medical assistance is denied; or
 - My eligibility for medical assistance ends; or
 - I inform the Ohio Department of Medicaid in writing that I wish to end my authorization.
- If I refuse to authorize the Ohio Department of Medicaid to get information about me from financial institutions, or I decide to end my authorization, I understand that my medical assistance may be denied or discontinued.
- I understand that when I send in this application it means I have permission from everyone whose information is on the form to submit their information to the Ohio Department of Medicaid and receive any communications about their eligibility and enrollment.
- I understand that the Ohio Department of Medicaid is authorized to collect information on this form, and other supporting information including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.
- I understand that if I am permanently institutionalized or age 55 or older when I receive Medicaid benefits, after my death the Estate Recovery Program will seek to recover payments for the cost of my care paid by Medicaid from my estate. The cost of my care may include the capitation payments that Medicaid pays to my managed care plan, even if the capitation payments are greater than the cost of the services that I actually received.

My right to an appeal

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

Sign this application. The person listed in STEP 1 should sign this application. If you're an authorized representative, you may sign here as long as the person listed in STEP 1 signed **APPENDIX C**.

I am signing this application under penalty of perjury which means I have provided true answers to all of 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. By signing the application, I am agreeing to all statements listed above.

☐ Check here if you are an authorized representative.

If you are 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 7

What To Do When You Complete This Application

Return this application to your local County Department of Job and Family Services office.

To search for your county JFS office, go to http://jfs.ohio.gov/County/County_Directory.pdf

THIS PAGE INTENTIONALLY LEFT BLANK.

You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. **Have the person who is offered the employer health insurance fill out questions 1-3 and ask the employer to fill out the rest of the form.** Attach a copy of this page for each job that offers coverage.

EMPLOYEE Information

1. Employee Name (First Name, Middle Name, Last Name)

2. Employee Social Security Number (SSN)

3. List the first and last names of each person in the employee's household and tell us if they could get health coverage through the employer named in question 4, below, even if they're not currently enrolled.

Name	Eligible for health coverage through this employer?	If yes, when can this person enroll in coverage?
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

EMPLOYER Information

Ask the employer to enter the information in questions 4-14.

4. Employer/Company Name

5. Person or Department we can contact about employee health coverage (we may contact this person if we need more information)

6. Employer Contact Address

7. City

8. State

9. Zip Code

10. Employer Contact Phone Number

11. Employer Identification Number (EIN)

12. Employer E-mail Address

Tell us about the health coverage offered by this employer.

13. Does the employer offer a health plan that meets the minimum value standard? A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.

☐ **YES.** Skip to question 14. ☐ **NO.** Stop and return this form to the employee.

14. How much would the employee have to pay for the lowest cost plan offered to the employee only that meets the minimum value standard? Don't include family plans. NOTE: If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

a. Employee would pay this premium \$

NOTE: Enter the lowest amount the employee would pay for health coverage that meets the minimum value standard.

b. Employee would pay this amount:

☐ Weekly☐ Every 2 Weeks☐ Twice a Month☐ Once a Month☐ Quarterly☐ Yearly

THIS PAGE INTENTIONALLY LEFT BLANK.

APPENDIX B

American Indian or Alaska Native (AI/AN) Family Member

Complete this appendix if you or a family member are American Indian or Alaska Native and are applying for coverage. 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 that 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, Middle, Last, Suffix)	First Middle Last Suffix	First Middle Last Suffix
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name: ☐ No	☐ Yes If yes, tribe name: ☐ No
3. Has this person ever received 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, a tribal health program, or urban Indian health program, 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, a tribal health program, or urban Indian health program, 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 the Interior (including reservations and former reservations) • Money from selling things that have cultural significance.	\$ How Often?	\$ How Often?

THIS PAGE INTENTIONALLY LEFT BLANK.

Section 1

1. Name of Applicant/Recipient	2. SSN
--------------------------------	--------

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 and your Medicaid benefits, 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 JFS office. If you are a legally appointed representative for someone on this application, submit proof with the application.

3. Name of Authorized Representative	4. Title	5. Company/Organization
6. Mailing Address		7. Apartment or Suite Number
8. City	9. State	10. Zip Code
11. Home Phone	12. Work Phone	13. Email Address

14. I authorize my representative to do the following on my behalf:

☐ Act on my behalf in all matters with the agency (“agency” includes the County Department of Job and Family Services [CDJFS], the Ohio Department of Medicaid [ODM], and ODM’s contracted designees).

OR only the specific actions selected below:

- ☐ Assist with my application/renewal for benefits
☐ Provide verifications to the CDJFS on my behalf
☐ Discuss and receive information regarding my financial and medical information including protected health information (PHI)*
☐ Other (*please specify*)
- ☐ Represent me at a state hearing
☐ Receive and respond to copies of all correspondences

15. This authority lasts until _____ (*specify a date or event*), or until it is revoked by me in writing.

***Note:** *You must complete Section 2 of this form if this authorization is intended to allow the use or disclosure of PHI.*

While this authorization is in effect, all notices sent by the CDJFS and/or ODM will also be sent to your authorized representative.

Signatures. This form has no effect unless signed by both the person granting authority and by the authorized representative. By signing below, the authorized representative agrees to maintain the confidentiality of any information regarding the applicant/recipient provided by the agency. If the authorized representative is a provider, staff member, or volunteer of an organization, then the authorized representative also agrees to adhere to the regulations cited in 42 C.F.R. 435.923(e).

16. Signature of Person Granting Authority (<i>Applicant/Recipient or Parent/Guardian</i>)	17. Date
18. Signature of Authorized Representative	19. Title (<i>if employee of an organization</i>)
	20. Date

APPENDIX C Assistance with Completing this Application (continued)**Section 2****Authorization for the Use and Disclosure of Protected Health Information**

1. Name of Applicant/Recipient	2. SSN
--------------------------------	--------

The County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM), and ODM's contracted designees (including Medicaid managed care organizations) are authorized to disclose my protected health information (PHI) to my authorized representative designated in Section 1 of this form.

I hereby authorize the use or disclosure of my protected health information (PHI) as described below.

I understand PHI can include the following types of information and authorize its disclosure: medical records; substance abuse care; vision care; reproductive care; mental health; communicable disease; pharmacy; HIV/AIDS; dental records; and psychiatric care.

3. This protected health information may be disclosed:
4. The information is being released for the following purpose(s):

Terms and Conditions

By signing below, I hereby authorize the disclosure of my PHI by the agency. I understand that:

- This authorization expires on the following date or event _____, or upon revocation by me in writing, whichever occurs first.
- I may revoke this authorization at any time. If I revoke this authorization, the revocation is not effective for the use or for the disclosure of my information that has already occurred.
- Any information used or disclosed pursuant to this authorization could be re-disclosed by the person or entity receiving the information and will likely no longer be protected by federal privacy regulations.
- This authorization is voluntary and that I may refuse to sign it. The provision of treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- In the event my records contain psychotherapy notes, a separate authorization may be required for the release of any psychotherapy notes.
- This authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

By signing below, I confirm that I have read and understand the contents of this authorization and confirm that the contents are consistent with my direction to the entity releasing my information.

5. Signature of Applicant/Recipient	6. Date
-------------------------------------	---------

If this form is signed by someone other than the Applicant/Recipient, please describe the authority to act on the individual's behalf (*such as Power of Attorney or Legal Guardian*). If not already on record with the agency, please provide legal documentation showing this authority.

APPENDIX D Additional Person

Complete APPENDIX D for your spouse/partner and children who live with you, and/or anyone listed on your federal income tax return if you file one. See page 6 for more information about who to include. If you don't file a tax return, remember to add all family members who live with you.

1. First Name, Middle Name, Last Name		2. Relationship to you
3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female	
5. Social Security Number (SSN)		
We need this if this person wants health coverage and has 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? (This person can still apply for health insurance even if he or she doesn't file a federal income tax return.) ☐ YES. Please answer questions a-c. ☐ NO. Skip to question c.		
a. Will this person file jointly with a spouse? ☐ Yes ☐ No If yes, list 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 else'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 this person married? ☐ Yes ☐ No		
9. Does this person want health coverage? Even if this person has insurance, there might be a program with better coverage or lower costs. ☐ YES. Answer questions 10-24. ☐ NO. Skip to the income questions in STEP 3.		
10. Does this person want help paying for medical bills from the last 3 months? ☐ Yes ☐ No		
11. Does this person have a medical condition that limits one or more daily activities (like bathing, dressing, daily chores, etc.)? ☐ YES. Please also complete APPENDIX E. ☐ NO.		
12. Is this person requesting in-home care or nursing home care? ☐ YES. Please also complete APPENDIX E. ☐ NO.		
13. Is this person pregnant? ☐ Yes ☐ No		
a. If yes, how many babies are expected during this pregnancy?		Expected due date (optional):
14. If not currently pregnant, was this person pregnant recently? ☐ Yes ☐ No		
a. If yes, how many babies were expected during that pregnancy?		Pregnancy end date:
15. Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No If yes, is this person a naturalized or derived citizen? ☐ Yes ☐ No		
16. If this person is not a U.S. Citizen or U.S. national, does this person have eligible immigration status? ☐ YES. Fill in this person's document type and ID number below. ☐ No Document type: Document ID number: Has this person lived in the U.S. since August 22, 1996? Is this person, his/her spouse, or his/her parent(s) a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No		

APPENDIX D Additional Person (continued)

17. If this person lives with at least one child under the age of 19, is he or she the main person taking care of this child?

☐ Yes ☐ No

18. Is this person going to school, in college, or in training? ☐ Yes ☐ No

If yes, please provide the following information:

Type of school: ☐ College/Higher Education ☐ Vocational ☐ GED ☐ Technical Training

Enrollment: ☐ Full Time ☐ Half Time ☐ Less than Half Time

19. Was this person in foster care at age 18 or older? ☐ Yes ☐ No

a. **If yes**, when did this person enter foster care?

b. When did this person leave foster care?

c. In which state was this person in foster care?

20. Is this person currently incarcerated (detained or jailed)? ☐ Yes ☐ No

If yes, please provide date of incarceration:

Expected date of release (*optional*):

21. Is this person currently or has this person ever served in the military? ☐ Yes ☐ No

22. Is this person currently receiving or has this person ever received benefits in another state? ☐ Yes ☐ No If yes, where?

23. Is this person Hispanic or Latino? (OPTIONAL – check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

24. RACE (OPTIONAL – check all that apply)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

APPENDIX E Medicaid for the Aged, Blind, or Disabled

You DO NOT need to answer these questions unless someone in the household is applying for Medicaid coverage because they're aged, blind, disabled, or wanting help with paying their Medicare premiums. This appendix should also be completed if someone in the household is applying for in-home care or nursing facility care.

Please read all questions carefully and complete each section to the best of your ability.

If you have any questions, please call 1-866-640-6446.

Estate Recovery

If you are permanently institutionalized or age 55 or older when you receive Medicaid benefits, after your death the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the capitation payments that Medicaid pays to your managed care plan, even if the capitation payments are greater than the cost of the services you actually received.

<https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM07400.pdf>

Tell us about who is applying. (If you have additional people on this application applying for Medicaid for the Aged, Blind, or Disabled, please make a copy of APPENDIX E and attach to the application.)

	PERSON 1	PERSON 2
1. Name (First, Middle, Last, Suffix)	First Middle	First Middle
	Last Suffix	Last Suffix
2. Is this person currently receiving or entitled to Medicare?	☐ Yes ☐ No If yes , Medicare number:	☐ Yes ☐ No If yes , Medicare number:
3. Is this person blind?	☐ Yes ☐ No	☐ Yes ☐ No
4. Is this person requesting in-home care or nursing facility care?	☐ Yes ☐ No If yes , select an option below: ☐ In-home care ☐ Nursing facility care	☐ Yes ☐ No If yes , select an option below: ☐ In-home care ☐ Nursing facility care
5. Is this person interested in applying for the Residential State Supplement (RSS) program? RSS is a program for low-income adults who are at least age 65 or who have disabilities. The RSS program helps with financial assistance so that individuals can live in Residential Facilities. Applicants must meet at least a Protective Level of Care in addition to other program eligibility criteria.	☐ Yes ☐ No	☐ Yes ☐ No

6. **Additional income this month:** Check all that apply. List the monthly amount and who receives the income.

If more than one person receives the same type of income, please use the rows marked 'Other – Type'.

Type	Y	N	Person	Amount
Supplemental Security Income (SSI)				
Veterans' Benefits				
Workers' Compensation				
Other – Type				
Other – Type				
Other – Type				

APPENDIX E Medicaid for the Aged, Blind, or Disabled (continued)

- 7. Tell us about the resources that belong to household members.** List all that apply to the individual applying for Medicaid for the Aged, Blind, or Disabled. If the individual is married, please also list all that apply to the individual's spouse.
Tell us the account/policy number and the value for each.
If you have more than one of the items listed below, please include information regarding each additional account or policy below in response to question 7.

Type	Y	N	Person	Account/Policy #	Value
401(k)/Keogh/IRA/Retirement Pension					
ABLE Account					
Agency Payment Card					
Annuity Account					
Burial Insurance					
Burial Space					
Cash/Uncashed Check/Uncashed Funds					
Certificate of Deposit (CD)					
Checking Account					
Continuing Care Retirement Community Entrance Fee					
Life Insurance - Term					
Life Insurance - Universal					
Life Insurance - Whole					
Long-Term Care (LTC) Insurance					
Money Market					
Mutual Fund					
Prepaid Burial Contract					
Promissory Note					
Property Agreement (Mortgage/Deed)					
Real Property Sold on Land Contract					
Savings Account					
Stocks/Bonds					
Tribal Gaming Ongoing Distributions					
Trust					
Other – Type:					

8. Tell us about any additional accounts or policies.

If you have multiple accounts and/or policies for the items listed above in question 6, please list the information below.

Type	Person	Account/Policy #	Value

9. Tell us about real property that belongs to anyone in the household. List all that apply.

Type	Y	N	Person	Address	Fair Market Value	Date Purchased	Date Listed for Sale
Building							
Real Estate Property of Non-Citizen Sponsor							
House/Condominium							
Land							
Life Estate							
Lot – Vacant							
Lot with Buildings							
Mobile Home							

10. Tell us about personal property that belongs to anyone in the household. List all that apply.

Type	Y	N	Person	Date Obtained	Fair Market Value
Collectibles/Jewelry					
Crops					
Tools					
Livestock/Poultry					
Other - Type:					

11. Tell us about any motor vehicles that belong to anyone in the household.

(Please include all vehicles that have a household member on the registration, even if not running.)

Type	Person	Year	Make	Model	Fair Market Value

12. Tell us about all resources listed in questions 6 through 10 that were sold, traded, or given away in the last 5 years.

Person	Description	Fair Market Value	Date Sold, Traded, or Given Away	Amount Sold For

13. Tell us about any additional expenses (not listed in Step 3) that you pay each month.

Type	Y	N	Person	Amount
Medical Expenses				
Medicare Premiums				
Housing Expenses				
Utility Expenses (Gas, Electric, Water, etc.)				
Other - Type:				
Other - Type:				
Other - Type:				