Ohio
Department of Medicaid

Application for Health Coverage & Help Paying Costs

ODM 07216 (7/2014)

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**.

THIS PAGE INTENTIONALLY LEFT BLANK.

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

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.

THIS PAGE INTENTIONALLY LEFT BLANK.

APPENDIX A

Ohio Department of Medicaid
ODM 07216 - A (7/2014)

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).

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.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**.

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
ODM 07216 - B (7/2014)

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?_____

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**.

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)

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**.

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.

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**.

APPENDIX E

Ohio Department of Medicaid
ODM 07216 - E (7/2014)

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	☐ 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 _____

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

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**.

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.

THIS PAGE INTENTIONALLY LEFT BLANK.

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: www.OhioSecretaryofState.gov or call 1-877-767-6446.

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.

Registering in Person
If you have a current valid Ohio driver's license, you must provide that number on line 10. If you do not have an Ohio driver's license, you must provide the last four digits of your Social Security number on line 10. If you have neither, please write "None."

Registering by Mail
If you register by mail and do not provide either an Ohio driver's license number or the last four digits of your Social Security number, you must enclose with your application a copy of one of the following forms of identification:

Current and valid photo identification, a military identification, or a current (within the last 12 months) utility bill, bank statement, paycheck, government check or government document (other than a notice of voter registration mailed by a board of elections) that shows your name and current address.

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.

Please see information on back of this form to learn how to obtain an absentee ballot.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

FOLD HERE

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.

3. Last Name | First Name | Middle Name or Initial | Jr., II, etc.

4. House Number and Street (Enter new address if changed) | Apt. or Lot # | 5. City or Post Office | 6. ZIP Code

7. Additional Mailing Address or P.O. Box (if necessary) | 8. County (where you live)

9. Birthdate (MO-DAY-YR) (required) | 10. Ohio Driver's License No. OR Last Four Digits of Social Security no. (one form of ID required to be listed or provided) | 11. Phone No. (voluntary)

12. **PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION** - Previous House Number and Street

Previous City or Post Office | County | State

13. **CHANGE OF NAME ONLY** Former Legal Name | Former Signature

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_____/_____/_____ (MO / DAY / YR)

FOR BOARD USE ONLY
SEC4010 (Rev. 6/14)

City, Village, Twp.

Ward

Precinct

School Dist.

Cong. Dist.

Senate Dist.

House Dist.

To ensure your information is updated, please do the following:

1. Print this form.
2. Complete all required fields.
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 www.OhioSecretaryofState.gov/boards.htm.

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (767-6446).

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: www.OhioSecretaryofState.gov or by calling 1-877-767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring identification to the polls in order to verify identity. Identification may include current and valid photo identification, a military identification, or a copy of a current (within the last 12 months) utility bill, bank statement, government check, paycheck, or other government document, other than a notice of an election or a voter registration notification sent by a board of elections, that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at:www.OhioSecretaryofState.gov or call 1-877-767-6446.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

Ohio Department of Job and Family Services

VOTER REGISTRATION
NOTICE OF RIGHTS AND DECLINATION

County Department of Job and Family Services

Name	Date

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ YES, I want to register to vote.
☐ 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 will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Signature

(This portion to be retained by agency)

- -

(This portion to be given to applicant/recipient)

Date

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 of your county 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

Address of County Prosecutor
City, State and Zip Code of County Prosecutor
Phone Number of County Prosecutor

Program Enrollment & Benefit Information

SNAP, Cash, Child Care and Medicaid

Department of Job & Family Services

"Strengthening Ohio Families with Solutions to Temporary Challenges"

CONTENTS

Have Questions? Contact:

Your County JFS Office | Locate contact information online at *jfs.ohio.gov/about/local-agencies-directory*

ODJFS Customer Access Line | Website: *jfs.ohio.gov* **Phone:** 866-ODJFS4U (866-635-3748)

Additional Resources:

TTY-Based Telecommunications Relay Service | Phone: 7-1-1

Ohio Domestic Violence Hotline | Website: *odvn.org* **Phone:** 800-934-9840

988 Suicide & Crisis Lifeline | Website: *988lifeline.org* **Phone:** 9-8-8 or 800-273-8255

Introduction: Benefit Program Overview

This booklet contains important information about the many benefit programs offered through the Ohio Department of Job and Family Services (ODJFS) and the Ohio Department of Medicaid (ODM). This booklet explains how to apply for programs, what information you need when you apply, and what to do if you disagree with decisions made about your eligibility. It also includes information about your right to be treated fairly and your rights and responsibilities as a consumer.

Ohio Assistance Programs and Services:

ODJFS and ODM have several programs that help low-income individuals. Each program has its own eligibility rules. Talk with your county JFS office about which benefits may be right for you. **Below is a list of assistance programs and supportive services you may be eligible to receive:**

Ohio Works First (OWF) - *also known as Cash Assistance*: Cash benefits for families in need for up to 36 months. You may be eligible for up to 60 months if you meet certain criteria.

Supplemental Nutrition Assistance Program (SNAP) - *also known as Food Assistance*: Benefits to help purchase food.

Child Care Assistance - *also known as Publicly Funded Child Care (PFCC)*: Financial assistance for child care costs to eligible caretakers while they work, go to school, or are participating in job training.

Child Support: Financial and medical support for children.

Refugee Services - *also known as Refugee Cash Assistance (RCA):* Helps refugees find work to support their families and to connect them with local schools and the community.

Employment Services: Job training and/or help finding a job.

Medicaid - *also known as Medical Assistance:* Assistance to help pay for health care for low-income and medically vulnerable Ohioans.

Unemployment Benefits: Temporary financial assistance to workers unemployed through no fault of their own. To file for unemployment by phone, call 877-644-6562.

Prevention, Retention and Contingency (PRC): Work support and other services to help low- income families overcome immediate barriers to achieve self-sufficiency.

Foster Care and Adoption Assistance: Provides subsidies and reimbursements to foster care and adoptive families.

Learning, Earning and Parenting Services (LEAP): Designed to encourage pregnant and parenting teens to attend and complete high school or the equivalent.

Kinship Programs: Provide benefits and services to caregivers so that children may be cared for in the home of relatives or other caregivers when their parents are unable to care for them.

How to Apply: The Application Process

Ways to Apply for Programs (SNAP, Cash, Medicaid, and Child Care Assistance)

Online: Create or access your online account at ssp.benefits.ohio.gov. You can fill out applications for all programs using your online account.

Mail or Fax: Mail or fax the completed application to your county JFS office. Locate their contact information online at jfs.ohio.gov/about/local-agencies-directory.

In-Person: Complete, sign, and turn in the application to your county JFS office. They will give you a receipt.

- **For SNAP, Cash, Medicaid, and Child Care Assistance,** find the *Application for Supplemental Nutrition Assistance Program (SNAP), Cash Assistance, Medical Assistance, or Child Care Assistance (JFS Form 07200)* at jfs.ohio.gov/form07200
- **For Medicaid only,** find the *Application for Health Coverage & Help Paying Costs (ODM Form 07216)* at medicaid.ohio.gov/static/Resources/Publications/Forms/ODM07216fillx.pdf

Phone: Call 844-640-6446.
For Medicaid only, call the Medicaid Consumer Hotline at 800-324-8680 to request an application or apply by phone.

Filling Out Your Application

Complete as much of the application as you can, however, be sure to include at least your name, address, and signature. If you are not sure how to answer a question, you can leave it blank. If you are unable to complete the application by yourself, you may need someone to be your Authorized Representative. You can have a friend or relative help you fill it out, or you can get help at your county JFS office. You can change your Authorized Representative at any time. They must be 18 years old or older and aware of your household circumstances.

You must sign and date the application before you turn it in to your county JFS office. Signing the application means that you are giving true and correct information to the best of your knowledge. If you are applying over the phone, you must complete an interview at that time in order for your application to be considered signed. **Note:** You may get help applying for Medicaid through local providers or hospitals.

Submitting Your Application and Next Steps

You may be required to complete an interview if you are applying for SNAP or Cash Assistance. For SNAP, Cash, and Child Care Assistance applicants, your county JFS office will determine your eligibility for these programs within 30 days of the date you turned in your application. Some households may qualify to have their SNAP applications processed within 24 hours or 7 days. Please go to the "SNAP Rights and Responsibilities" section on Page 8 for more information. For Medicaid applications, your county JFS office will determine your eligibility for Medicaid within 45 days of the date you turn in your application.

Your county JFS office will tell you any verifications you need to submit and will also give or send you the *Verification Request Checklist (JFS 07105)*. The checklist will have listed the deadline to submit the verifications necessary to determine your eligibility. Your county JFS office will send you a notice about your eligibility for benefits after your application has been processed. If you have any questions, please review any notice(s) you receive carefully as they will include helpful resources and contact information.

Receiving Your Application Decision

If you are approved for benefits, you will get an Approval notice with information about your benefits. However, if you are denied you will be sent a Denial notice explaining the decision.

Disagree with the decision? If you want to learn more about your options, go to Page 16.

How to Apply: Frequently Asked Questions (FAQs)

What happens if I miss my interview?

If you miss your interview, contact your county JFS office right away. If you do not complete your interview with your county JFS office within 30 days from the date that you turned in your application, your application may be denied and you will have to reapply.

When should I expect a response by?

SNAP, Cash, and Child Care Assistance: Your county JFS office will determine your eligibility for these programs within 30 days of the date you turned in your application. If you are eligible, your benefits may be approved back to the date you turned in your application.

Child Care ONLY: If your application is denied, you may be responsible to pay any Child Care provider who you have employed since you turned in your application.

Medicaid: Your county JFS office will determine your eligibility for Medicaid within 45 days of the date you turned in your application. They may have to conduct a Disability Determination if you are claiming a disability, which may take up to 90 days. If you are eligible, they may approve your Medicaid back to the date you turned in your application. If you have medical bills from the 3 months before you applied, tell your county JFS office. They may approve you for Medicaid for those 3 months.

What if I need communication assistance?

Those who are deaf, hard-of-hearing, deaf with low vision, or speech-disabled may use a TTY/TDD telephone to contact the Ohio Relay Service at 800-750-0750. Be sure to have the telephone number of the agency you wish to call ready, so that someone at the Ohio Relay Service can help you. For questions, comments, problems, or complaints about the Ohio Relay Service, call 800-325-2223 (TTY/TDD and Voice).

What if English is not my preferred language?

If English is not your preferred language, you can receive interpretation and translation services by calling your county JFS office. They will provide the information to you in your preferred language (either verbally or in writing).

Supplemental Nutrition Assistance Program (SNAP)

The Ohio Supplemental Nutrition Assistance Program (SNAP), formally known as the Food Assistance Program, helps households that have limited income and resources buy food. This program is designed to increase buying power, raise nutritional levels, and safeguard the health and well-being of individuals and families in the State of Ohio.

How Will I Know if I am Eligible for SNAP and How Do I Apply?

You may qualify for benefits if your household's gross monthly income (the total monthly earned and unearned income) is at or below 130% of the federal poverty guidelines. These guidelines change yearly; you can find the current figures at aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/. Households that contain an elderly or disabled person have higher income eligibility limits.

What Information Do I Need to Give to the County JFS Office When Applying for SNAP?

You may need to give the information below about yourself and all household members.

- Income (ex: pay stubs, tax records, benefit award notices, or child support notices)
- Identity document for the applicant or Authorized Representative (ex: a Driver's License or State ID)
- Housing and utility costs
- Social Security Number (SSN) or proof that you've applied for one
- Proof of residency
- Eligible qualified non-citizen status
- Any child care or dependent care costs
- Any child support you pay for children not living with you
- Any non-reimbursable medical expenses (including prescriptions) for those with disabilities or for those over age 60

Your county JFS office may verify any information that you provide by contacting other agencies or individuals. You may also be asked to provide other documents. If you need help getting any document(s), tell your county JFS office right away as they will help you in getting the required information.

Additional Social Security Number (SSN) Information for SNAP

Social Security Numbers will be used to check the identity of household members, prevent duplicate participation, and make changes to your case. If any household member does not provide their SSN, they will be designated as a non-applicant. This means they will NOT be considered as an applicant and will not be eligible for SNAP.

Providing any requested information, including the SSN of each household member, is voluntary. However, failure to provide requested information to establish your eligibility for assistance will result in the denial or reduction of SNAP benefits to your household. Information collected on the application may be disclosed to law enforcement officials for the purpose of apprehending individuals fleeing to avoid the law.

If you apply for, or are currently getting SNAP benefits, and it is found that you have an outstanding felony warrant, or are in violation of probation or parole through an SSN match, your current address may be released to the appropriate law enforcement agencies.

Household members who are not applying for SNAP are still required to answer questions that may affect the eligibility of the applicant's household members. Responses to questions about income, resources, striker status, and intentional program violations may be considered. Other members of your household will still be able to get SNAP benefits if they are eligible.

Supplemental Nutrition Assistance Program (SNAP) (Continued)

When Will I Receive My SNAP Benefits?

If you are approved, your monthly benefit amount will be loaded onto your Ohio Direction Card (formerly known as the Ohio EBT Card) on an assigned and scheduled date sometime between the 1st and the 20th of the month. Your Approval notice will tell you the date that benefits are loaded to your card. You can use your Ohio Direction Card like a commercial debit or ATM card. For more information on the Ohio Direction Card, visit *connectebt.com/ohebtclient/ebt_link.jsp*. Resources are available in multiple languages if you click on the "Program Materials" tab.

Need Help with Your Ohio Direction Card?

Call Customer Service at 866-386-3071, toll-free and available 24/7.
Customer Service will help you with: Answering Frequently Asked Questions (FAQs) about your card, activating your Ohio Direction Card, finding your Ohio Direction Card number (if you do not know it), selecting or changing your PIN, checking your account balance, reporting and replacing a lost, stolen, or damaged Ohio Direction Card, and/or reporting benefits fraud. For additional information on protecting your benefits from fraud, go to Page 23.

How Much Are Monthly SNAP Benefits?

Benefit amounts are determined based on household size, earned/unearned income, expenses, and resources, in some situations. Household size is defined by the number of people in your household who purchase and prepare food together. Expenses may include your shelter costs, gas, electric, water, sewer, phone, and medical expenses (if applicable), as well as any child support or child care payments. Household resources include cash, savings, and stocks.

What Can I Buy With My SNAP Benefits?

Most grocery stores, convenience stores, and farmers' markets accept your Ohio Direction Card. Visit *https://jfs.ohio.gov/cash-food-and-refugee-assistance/food-assistance/food-programs/electronic-benefit-transfer/information-for-ohio-direction-cardholders* to locate farmers' markets in your area.

You may use your card to buy: Fruit, vegetables, meat, dairy, seafood, non-alcoholic beverages, canned foods, and other cold grocery items at major retailers or online.

You may NOT use your card to buy: Alcoholic beverages, tobacco, vitamins and/or medicines, hot food products that are made to be eaten immediately (including prepared food from grocery stores and restaurants), and non-food items (such as pet food, diapers, paper products, soaps, and household supplies).

You Must Report Changes:

1. **If your monthly, household income goes above the monthly income limit** before taxes for your household size. Refer to the Income Guideline Reference table on the *SNAP Change Reporting form (JFS Form 04196)* by visiting *https://www.odjfs.state.oh.us/forms/num/JFS04196/pdf/*.
2. **If you or a member of your household is an Able-Bodied Adult Without Dependents (ABAWD) who is working and subject to the time limit and work requirements, you must report if hours worked are less than 20 hours weekly or 80 hours monthly.**
3. If you or a member of your household **wins $4,250 or more (before taxes or withholdings) in lottery or gambling winnings.** In Ohio, lottery or gambling winnings are cash payouts won in single games. These include but are not limited to payouts from: Casinos, racinos, slot machines, poker, keno, and/or other forms of gambling.

Supplemental Nutrition Assistance Program (SNAP) (Continued)

Note: A household is not eligible to participate in SNAP if a household member has won substantial lottery or gambling winnings. The household will remain ineligible for SNAP until it meets the allowable income and resource eligibility requirements.

You Can Report Changes by:

- Using your online account. You can create one at ssp.benefits.ohio.gov/.
- Completing and submitting *SNAP Change Reporting (JFS Form 04196)* to your county JFS office.
- Phone, mail, in-person, or fax to your county JFS office. Search for your local county JFS office at https://jfs.ohio.gov/about/local-agencies-directory.

Note: Any changes you report may affect your SNAP, Cash, or Medical Assistance benefits.

You have until the 10th of the month following when the change first happened to tell your county JFS office (ex: if your income changes during April, you must report the change by May 10th).

Interim Report:

If you are certified for 12 months, you will receive an Interim Report in the mail during the 5th month of your 12-month certification period so you can provide updated information.

If you are certified for 36 months, you may receive an Interim Report every fifth month of your certification period if your household circumstances change.

If you do not complete, sign, and return the Interim Report by the 15th of the month in which it was issued or provide verification when asked to attach proof, you will receive an Interim Report Reminder notice. If you need help completing your Interim Report, please contact your county JFS office. **You must complete and sign the original Interim Report or Interim Report Reminder notice by the end of the month in which it was issued, or your SNAP benefits will end.**

SNAP Citizenship Status Requirement

All individuals in your household who want to receive SNAP benefits must provide information about their citizenship or immigration status. If anyone in your household does not want to provide information about their citizenship or immigration status, the state will designate that person as a non-applicant. This means that person will not be eligible for SNAP.

SNAP Penalty Warning

The information you provide to your county JFS office will be reviewed for accuracy. **If you knowingly provide false information, you may be: fined, denied SNAP benefits, barred from SNAP for 12+ months or permanently, subject to prosecution, and/or imprisoned.**

Cash Assistance

Ohio Works First (OWF) provides Cash Assistance to eligible low-income families with children for up to 36 months. If you and your family are refugees and you are not eligible for OWF, you may be able to receive Cash Assistance through the Refugee Cash Assistance (RCA) program for your first 12 months in the United States.

What Determines My Eligibility for OWF Cash Assistance?

To Receive OWF Cash Assistance, You Must:

- Be a resident of Ohio
- Be a U.S. citizen or qualified non-citizen
- Be at least 6 months pregnant or responsible for a child under the age of 19
- Be underemployed, unemployed, or about to be unemployed

After your 36-month period of receiving benefits ends, you may file for an extension of benefits up to a total of 60 months. To file for an extension, please contact your local county JFS office. While Federal requirements limit the Cash Assistance program to 5 years, there may be instances where benefits can extend beyond this time limit. For information regarding these extensions please contact your county JFS office. Adults or minor heads of household may be required to participate in work activities. Examples of work activities may include county-approved on-the-job training, community service and/or education.
Please inform your county JFS office of any potential employment barriers, such as difficulties with transportation, child care, or medical limitations.

Eligible adults or minor heads of household must also sign a *Self Sufficiency Contract (JFS Form 03801)* or an *Individual Opportunity Plan (JFS Form 03004)* that your county JFS office will review with you. Failure to sign or meet the terms of the contract without good cause will result in termination of benefits for the household. For more information on good cause reasons, please review the *Self Sufficiency Contract (JFS 03801)*.

If you quit a job without just cause, you will not be able to receive or apply for benefits for the following six months. “Just cause” for voluntarily terminating employment includes, but is not limited to the following reasons:

1. Discrimination by an employer based on age, race, sex, color, disability, religion, or national origin.
2. Work demands or conditions that make continued employment unreasonable, such as working without being paid on schedule.
3. Employment that has become unsuitable due to any of the following: the wage is less than the federal minimum wage, the work is at a site subject to a strike or lockout, the documented degree of risk to health and safety is unreasonable, or if you are physically or mentally unfit to perform the employment, as documented by medical evidence or by reliable information from other sources.

Households Are Not Eligible for OWF Cash Assistance if:

- *The Self Sufficiency Contract (JFS 03801)* or *Individual Opportunity Plan (JFS 03004)* is not signed
- After signing the contract, household members do not comply with the terms of the contract
- Household income exceeds the allowable amount for the household size
- Benefits have been received fraudulently

Additional individuals who are not eligible include: Fugitive felons, probation/parole violators, an individual who does not meet the qualified non-citizen requirement, or individuals convicted for fraudulently misstating where they live in order to receive benefits.

Cash Assistance (Continued)

What Information Do I Need to Give to the County JFS Office When Applying for Cash Assistance?

Examples of the information that you may need to be provide about yourself and your household members include:

- SSN or proof that you've applied for one
- Income (ex: pay stubs, tax records, or child support notices)
- Proof of citizenship
- Court documents and birth certificates when specified relatives apply
- Identity (ex: a driver's license or state ID)
- Any child care or dependent care costs

How Do I Get My Cash Assistance?

You may choose to receive your monthly benefits through either direct deposit into your checking or savings account or through the Way2Go (a prepaid MasterCard). The amount of benefits you receive depends on a number of factors, including your responses to application questions and household size and income.

Note: The Way2Go may be used at banks, ATMs, and most retailers that accept MasterCard. It may not be used at liquor stores, casinos, gaming establishments, or adult entertainment establishments in which performers disrobe or perform in an unclothed state for entertainment purposes.

Ohio Works First (OWF): SSN Information

Each person in your household who wants to receive OWF Cash Assistance must provide their SSN when applying. Public Children Services Agencies (PCSAs) may also use your SSN to provide services to your family and to verify benefits or services. If you apply for, or are receiving OWF Cash Assistance or are receiving PRC services, and it is found that you have an outstanding felony warrant or are in violation of probation or parole through an SSN match, your current address may be released to appropriate law enforcement agencies. Your SSN may also be used for purposes of investigations, prosecutions, and criminal or civil proceedings that are within the scope of law enforcement agencies' official duties.

You Must Report Changes:

If you receive OWF Cash Assistance or RCA, you must report the following changes within 10 days of the date they occur:

1. Changes in family income (earned or unearned) by more than $50
2. When a household member becomes pregnant, or the pregnancy ends
3. When a school-age child drops out of school
4. Changes in household composition
5. Changes in child support responsibilities
6. Address changes, including relocation to another county
7. Information related to an absent parent changes
8. A minor parent's living arrangement changes
9. A household member violates a condition of probation or parole
10. A household member becomes a fugitive felon

Cash Assistance Rights and Responsibilities

OWF Cash Assistance: Child and Spousal Support

If you receive child or spousal support payments and are approved for OWF Cash Assistance, the State will keep all or part of your child or spousal support payments to cover the cost of the OWF Cash Assistance benefits.

As a condition of your eligibility for OWF, you are required to cooperate with the Child Support Enforcement Agency (CSEA) in establishing paternity or in securing support from the absent parent(s). For more information, review the *Notice to Individuals Applying for or Participating in OWF Regarding Cooperation with the Child Support Enforcement Agency (CSEA) (JFS Form 07092)* at the end of this guide.

Assignment of child or spousal support becomes effective the first of the month following the date you are approved for OWF Cash Assistance. Any child or spousal support you received prior to this will be considered when determining how much support you are eligible for in the first few months after you apply. If you receive past-due child or spousal support that accumulated before the month you started to receive assistance, you will be allowed to keep that amount.

Refugee Resettlement Program

Everyone in your family who wants to receive Refugee Cash Assistance (RCA) or Refugee Medical Assistance (RMA) under the Refugee Resettlement Program must provide information about their immigration or citizenship status. Certain members of your family may be ineligible for assistance because of their immigration status. If that happens, other family members may still be able to receive assistance if they are otherwise eligible. If you want to find out whether other family members are eligible for RCA or RMA under the Refugee Resettlement Program, you will need to provide information about their citizenship or immigration status. You will also need to answer questions about your family's income and other questions asked by the county JFS office. Although the county JFS office may request that you provide an SSN when you apply for RCA or RMA under the Refugee Resettlement Program, you do not have to provide an SSN. If you do provide an SSN, the county JFS office must tell you how it will be used.

Medicaid

Ohio Medicaid and related programs provide access to health care services for qualifying individuals, including children, pregnant women, parents, seniors, and people with disabilities.

What Determines My Eligibility for Medicaid?

To receive Medicaid, you must:

- Live in Ohio
- Be a U.S. citizen or a qualified non-citizen
- Provide your SSN, if applicable
- Cooperate with the Child Support Enforcement Agency (CSEA) to establish the paternity of and obtain medical support for any Medicaid-eligible child
- Cooperate with identifying and pursuing any person or company who may be responsible for your medical care or services
- Apply for and accept any other benefits you should be getting (such as Supplemental Security Income, Social Security Disability Insurance, annuities, or veterans' benefits)
- Meet the income, resource, and other program requirements

Medicaid Coverage Chart

SSI Medicaid: Medicaid coverage for individuals who receive Supplemental Security Income (SSI) benefits.

Adult Extension: Medicaid coverage for individuals ages 19-64.

Parents and Caretaker Relatives: Medicaid coverage for parents and caretaker relatives with children under age 18.

Pregnant Women: Medicaid coverage for women throughout the pregnancy and 12 months postpartum.

Children: Medicaid coverage for children up to age 19. Coverage for children in families with incomes above 156% of the federal poverty level is available only if the children have no other creditable health insurance.

Presumptive Eligibility: Immediate, time-limited Medicaid coverage for eligible individuals.

Presumptive Eligibility for Children: Immediate, time-limited Medicaid coverage for children up to age 19.

Presumptive Eligibility for Pregnant Women: Immediate, time-limited Medicaid for ambulatory prenatal care for pregnant women. This does not cover inpatient labor or delivery.

Refugee Medical Assistance (RMA): Time-limited Medicaid coverage for refugees. The program provides a medical screening and other medical services to qualified non-citizens.

Non-Citizen Emergency Medical Assistance (NCEMA): Medicaid coverage for the treatment of emergency medical conditions for certain individuals who meet all Medicaid requirements other than the citizenship requirements. Resources may be required to determine eligibility for NCEMA.

Transitional Medical Assistance (TMA): Up to six months of Medicaid and potential for an additional six months of Medicaid coverage with quarterly reporting for families who would otherwise lose coverage because a family member got a new job or is earning more money.

Aged, Blind, or Disabled (ABD): Medicaid coverage for individuals who are at least 65 years old and individuals of any age who are blind or disabled.

Medicaid Buy-In for Workers with Disabilities (MBIWD): Medicaid coverage for working, disabled individuals ages 16 to 64. If income is above a certain amount, individuals may need to pay a premium to get MBIWD.

Medicaid (Continued)

Medicaid Coverage Chart

Medicare Premium Assistance Program (MPAP): Medicaid assistance programs that help pay Medicare costs.

- Qualified Medicare Beneficiary (QMB): Pays Part A and B premiums, deductibles, copays, and coinsurance.
- Specified Low-Income Medicare Beneficiary (SLMB): Pays Part B premiums only.
- Qualifying Individual (QI): Pays Part B premiums only.
- Qualified Disabled and Working Individuals (QDWI): Pays Part A premiums only.

Residential State Supplement (RSS): A supplemental cash payment program for aged, blind, or disabled individuals who meet a protective level of care. RSS helps to pay the costs of living in certain residential care facilities.

Long-Term Care (LTC) or Home and Community-Based Services (HCBS) Waivers: Available for individuals who have special care needs, as determined by a health care provider and meet an intermediate or skilled level of care.

Program for All-Inclusive Care for the Elderly (PACE): A "total care" program run by both Medicare and Medicaid in Cuyahoga County.

Breast and Cervical Cancer Project (BCCP): Medicaid coverage for certain individuals who need treatment for breast or cervical cancer, or breast or cervical pre-cancerous conditions. These individuals must have been screened for the BCCP program by the Ohio Department of Health before applying for BCCP Medicaid.

Children in Care/Former Foster Children: Medicaid coverage for children in the custody of a public children services agency (PCSA), in receipt of foster care or adoption assistance under Title IV-E, or in receipt of state or federal adoption assistance. The program also covers individuals who aged out of foster care on their 18th birthday, until they turn 26 years old.

Continuous Eligibility for Children: Once found eligible for Medicaid, every child up to age 19 receives 12 months of continuous coverage.

Medicaid (Continued)

Which Health Care Services Are Covered by Medicaid?

Medicaid covers many health care services such as preventative care and home health services, but for some services, you may need to pay a copay. There are no copay requirements for pregnant women and children (up to 21 years old). Medicaid also covers well-child checkups including immunizations for newborns through age 20 through the Healthchek program.

You can find more information on these and other services that Medicaid covers at *medicaid.ohio.gov/families-and-individuals/srvcs/services*.

Help with Past-Due Medical Bills:
If you have medical bills from any of the three months before you applied, those bills may be covered if you are eligible. Contact your county JFS office for more information.

Annuities:
If you need Medicaid and have an annuity, you will have to name the State of Ohio as the remainder beneficiary in the first position (unless you have a spouse or a minor child).

Estate Recovery: If you receive Medicaid after you turn 55 years old or while you are considered permanently institutionalized, after your death, Medicaid will seek repayment for the cost of the services provided to you. Medicaid will collect this debt from real or personal property (such as your house, bank accounts, trusts, life insurance, retirement funds, or stocks and bonds).

The Attorney General's office handles estate recovery. For more information, contact:

Medicaid Estate Recovery Unit
Collections Enforcement
30 E Broad Street, 14th Floor
Columbus, Ohio 43215

Estate recovery may be delayed or may not occur if you have:

- A surviving spouse
- A surviving child (up to 21 years old)
- A surviving blind or disabled child of any age who was living with you
- A surviving sibling or child who cared for you in your home
- Received only Medicare Premium Assistance Program services on or after January 1, 2010

Note: Even if none of these apply, your heir may claim that estate recovery would cause an undue hardship for them.

Ohio's Partnership for Long-Term Care Insurance: Ohio long-term care insurance companies can now offer policies that qualify under Ohio's Long-Term Care Partnership Insurance Program. Partnership insurance offers a way for individuals to buy long-term care insurance, receive policy benefits, and protect a matching amount of assets if they need to apply for Medicaid. As a Medicaid recipient, you may make the decision to buy long-term care insurance. Visit *insurance.ohio.gov/consumers/long-term-care/partnership-ltc-ltc4me* for more information.

Medicaid (Continued)

Extra Help Medicare Program:
If you have Medicare Part D coverage, Medicaid will not pay for your prescription drugs. However, you may apply for "Extra Help," a Medicare program that helps individuals with limited income and resources pay for Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance. If you are eligible for Extra Help, you won't have to pay a deductible and your copay will be reduced.

For more information:
Call 800-MEDICARE (800-633-4227)
Visit *medicare.gov*

Home and Community-Based Services (HCBS) Waivers:
HCBS waivers help Medicaid-eligible individuals remain at home instead of going to a nursing home, hospital, or facility for individuals with developmental disabilities. Individuals enrolled in Medicaid waiver programs may receive nursing, Activities of Daily Living (ADLs), and skilled therapy services.

For more information:
Visit *medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/hcbs/waivers*

Medicaid Rights and Responsibilities

There are several categories of Medicaid, each with separate requirements. In general, you must:

- Give your county JFS office all requested documents
- Let your county JFS office know of any changes in your household within 10 days
- Cooperate with the application, renewal, auditing, and quality control processes
- Select a managed care plan, if required, as soon as possible

If you need help applying or reapplying for Medicaid, or getting the requested documents, ask your county JFS office for help.

Medicaid Citizenship and Immigration Status

Individuals who want to receive Medicaid must provide information about their citizenship or immigration status. If you are applying for a child, you must provide information about the citizenship or immigration status of the child.

Individuals in the same household who do not want to receive Medicaid do not have to provide information about their citizenship or immigration status. Individuals who are applying for Non-Citizen Emergency Medical Assistance (NCEMA) do not have to provide information about their citizenship or immigration status.

Child Care Assistance

The **Publicly Funded Child Care (PFCC) program** helps parents pay for child care while they are working, in school, or in training. To qualify, you must meet certain financial and non-financial requirements.

How Do I Apply for Child Care?

You may apply for PFCC online at ssp.benefits.ohio.gov, by phone at 844-640-6446, or by filling out the *Application for Supplemental Nutrition Assistance Program (SNAP), Cash, Medical, or Child Care Assistance (JFS 07200)* and submitting it to your county JFS office via mail, fax, or in-person. You can get this form from your local county JFS office or at jfs.ohio.gov/form07200.

You may also obtain the *Early Childhood Education Eligibility Screening Tool (JFS 01121)* and the *Publicly Funded Child Care Supplemental Application (with Voter Registration) (JFS 01122)* from your Early Childhood Education (ECE) Services provider and submit both completed documents to your local county JFS office.

What Information Do I Need to Provide When Applying for PFCC?

You will need to provide the following information about yourself and all household members:

- Information on every household member and citizenship for child(ren) needing care (ex: birth certificate or citizenship documents)
- Income (ex: pay statements, tax records, benefit award notices, or child support notices)
- Employer/Education/Training Information
- Name and Address of Child Care Provider

What Is Special Needs Child Care?

Special needs is when a child has one or more chronic health conditions and/or does not meet age-appropriate developmental milestones. Children who receive special needs child care services may continue to receive PFCC until their eligibility period ends once the child turns 18.

If you feel your child is in need of special needs child care, be sure to indicate this on your application.

Types of Child Care Available:

- **Licensed Child Care Centers:** Care that is provided in a center or school setting and serves more than seven children
- **Family Child Cares:** Care that is provided in the provider's home
- **In-Home Aide:** Care that is provided in the family's home
- **Educational Programs Licensed by the Ohio Department of Education (ODE):** Preschool and School-aged Early Care
- **Day Camps:** Recreational, educational, or other enrichment programs for school-aged children

How to Find a Child Care Provider:

Caretakers may select any program approved to offer PFCC. If you would like help selecting a provider, use the Child Care Directory at childcaresearch.ohio.gov. The directory allows you to search by location, program type, services offered, hours of operation, and Step Up To Quality rating. Licensing inspections and substantiated complaints are also available for review.

What is Step Up To Quality?

Step Up To Quality is Ohio's quality-rating system for child care programs. Ratings are awarded based on the program's implementation of standards that go beyond the minimum health and safety standards. For more information, visit the DCY child care website at https://childrenandyouth.ohio.gov/for-providers/step-up-to-quality.

Am I Responsible for Paying for Child Care Services?

You may be required to pay for part of your child care in the form of a copayment. The amount you pay is based on your gross monthly income and family size.

What Am I Responsible for?

If you receive PFCC, you are responsible for:

- Choosing a provider that has an active provider agreement with ODJFS
- Paying any required copayment (if applicable) to the provider. If you fail to pay the required copayment, your PFCC may be terminated
- Accurately recording your child's attendance at the Child Care program by utilizing an automated attendance tracking system

You Must Report Changes:

You must report the following changes within 10 days of the date they occur:

1. Changes in family income
2. When a preschool child becomes a school-age child and begins attending elementary school
3. When a school-age child changes schools
4. Changes in household composition
5. Changes in caretaker participation in a qualifying activity
6. Address changes, including relocation to another county

Appealing Your Decision: Next Steps

You have two options when appealing JFS' decision about your eligibility for benefits:

1) **County Conference:** This is an informal meeting with your county JFS office. Check the "I want a County Conference" box on the *State Hearing Request Form (JFS Form 04069)* or contact the county JFS office to request a County Conference.

2) **State Hearing:** This is a virtual meeting with a hearing officer from ODJFS and a representative from your county JFS office; you will not have to go to court. You can call in to participate in your State Hearing by telephone or by video using your smart phone, tablet, or computer.

Ways to Appeal:

Turn in the hearing request online through the Bureau of State Hearings' State Hearing Access to Records Electronically (SHARE) Portal hearings.jfs.ohio.gov/share

- Log in to the SHARE Portal using your Case ID and password to turn in your request.

Email bsh@jfs.ohio.gov and in the subject line, put "State Hearing Request"

- In the message, include your name, case number, and reason for requesting a hearing, or attach a copy of the completed State Hearing Form.

Mail the State Hearing Form to Bureau of State Hearings

- P.O. Box 182825, Columbus, OH 43218-2825

Call the ODJFS Consumer Access Line at 866-635-3748 and follow the instructions for State Hearings

Contact your county contact by mentioning this notice and turning in the completed attached form

- You may also contact your county contact by phone.

Fax the State Hearing Form to your county JFS office

Note: You must ask for a hearing within 90 days of the mailing date of the notice. If the county JFS office proposed terminating or reducing your benefits and you want your benefits to continue pending the hearing, the Bureau of State Hearings must receive your request for a State Hearing within 15 days of the mailing date of the notice. If the hearing decision is not in your favor, you may have to return benefits.

The State Hearing Process

Before the State Hearing:

You can request a State Hearing or access State Hearing information through the Bureau of State Hearings' State Hearing Access to Records Electronically (SHARE) Portal. You can access the SHARE Portal online at hearings.jfs.ohio.gov/SHARE/ and log in with your Ohio Benefits Self-Service Portal user ID and password, or register for a new account. The SHARE Portal is the easiest and fastest way to request a hearing and stay informed about your hearing's status. After your request for a hearing is received, the Bureau of State Hearings will send you a notice with the date and time of the hearing. This notice will be sent to you at least 10 days before the hearing. The notice will also contain important information about how to join the hearing either on the telephone or virtually. If you are not able to join the hearing using one of these methods, or if you have any scheduling considerations, you must contact the Bureau of State Hearings at 866-635-3748 as soon as you receive the notice for the hearing. This information is also available once you log into the SHARE Portal and through the automated information available at 866-635-3748 and will contain information about how to participate in your hearing.

The State Hearing Process (Continued)

Before the State Hearing (Continued):

Assistance at the State Hearing

Someone else may help you with your State Hearing (a lawyer, social worker, friend, relative, etc.). They may ask for a hearing and go to the hearing for you if you send your signed authorization to your county JFS office.

Before and during the hearing, you may look at your case file and any other evidence the county JFS office has. You may also examine the rules being used to decide your case. The county JFS office will make free copies for you to help you get ready for the hearing. If you need copies, please call your county JFS office before your hearing.

Legal Assistance

If you want legal help at the hearing, you must make arrangements before the hearing. Contact your local Legal Aid program to see if you qualify for free help. If you don't know how to reach your local Legal Aid office, call 866-LAW-OHIO (866-529-6446), toll-free, or search the Legal Aid directory at ohiolegalhelp.org/find-your-legal-aid. If you want a notice of the hearing sent to your lawyer, you must give the Bureau of State Hearings your lawyer's name and address before the hearing.

Subpoena

You can ask ODJFS to subpoena documents or witnesses that would not otherwise be available and that are essential to your case. You must request the subpoena at least five calendar days before the date of the hearing and include the name and the address of the person or document you want subpoenaed.

At the State Hearing:

Please do not wait for the hearing officer to call you. You must dial-in, or go online, to attend your hearing. It is highly recommended to join the hearing a few minutes before, but no later than, your scheduled start time. Because hearing officers are scheduled for many hearings each day, your hearing may not start on-time. We ask that you allow 30 minutes for the hearing officer to arrive. **Note:** If you do not dial-in or attend your hearing online, the hearing officer will not call you for your hearing.

At the hearing, you will meet with a county JFS office representative and a state hearing officer to talk about your case. Your county JFS office representative will explain the county JFS office's action. You can explain why you don't agree with the decision. The hearing officer will listen to both sides, may ask questions, and will tape-record the conversation. After the hearing decision is issued, you can get a free copy of the recording by contacting the Bureau of State Hearings.

After the State Hearing:

After the hearing, the hearing officer will review your case fairly and objectively. The hearing officer will make a decision based on the information given during the hearing and whether the rules were applied correctly and you will receive the hearing decision in writing.

SNAP Benefits Decision:

You will be sent a written decision within 60 days of the date you requested the hearing.

ALL OTHER Program Decisions:

You will be sent a decision within 90 days from the date you requested the hearing.

To check the status of your appeal, call 866-635-3748 or check the SHARE portal.

Frequently Asked Questions (FAQs)

Is there another way to work out my concerns?

Having a county conference at the county JFS office is often a quicker way to resolve your appeal. At the conference, a county worker will look over your case and can correct any mistakes. You can call the county JFS office to request a County Conference. If the problem is not solved at the conference, you can still ask for a State Hearing.

The Bureau of State Hearings can also assist you with resolving your appeal with the county JFS office through the pre-hearing resolution process once you request a hearing.

What if I missed my State Hearing?

If you or your Authorized Representative do not attend the hearing, the Bureau of State Hearings will send you a dismissal notice. If you want to continue with your hearing request, you must contact the Bureau of State Hearings within 10 days and explain why you or your Authorized Representative did not come to the hearing.

The hearing officer will decide whether you had good cause to miss the hearing and may request that you provide verification of good cause. If you do not contact the Bureau of State Hearings within ten calendar days and show good cause, your hearing will be dismissed. The county JFS office will then proceed with the action it was planning to take. If you don't agree with the dismissal, the dismissal notice will explain how to ask for an
administrative appeal.

What if I do not agree with the hearing decision?

If you do not agree with the hearing decision, you can ask for an administrative appeal. The written decision notice from the hearing officer will tell you how to ask for an appeal. An administrative appeal must be requested within 15 days of the date the State Hearing decision was issued.

If you don't agree with the administrative appeal decision, you do not have the option to have another hearing. However, you can ask for a judicial review. A judicial review is an appeal to the court. You must file a judicial review within 30 days of the date of the administrative appeal.

Rights & Resources: Social Security Numbers (SSN)

You must provide your county JFS office with an SSN, or apply for an SSN, for each person applying to receive assistance. You may not need to provide an SSN in all situations. The collection of this information, including the SSN of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036, Section 1137(a) of the Social Security Act, 42 C.F.R. 435.910, and Rules 5101:4-3-22, 5101:1-1-03, 5160:1-2-10, and 5101:1-3-09 of the Ohio Administrative Code.

Personal Information

The information you give your county JFS office is private and will be kept confidential and secure. Your information will only be viewed by JFS staff actively handling your case or participating in a quality control review.

Without your permission, JFS cannot share the following information:

- Names and addresses
- Medical services provided
- Personal information
- Social and economic conditions or circumstances
- Medical data, including diagnosis and history of disease or disability
- Information received for verifying income eligibility and how much assistance you were given
- Any information received about other companies that may be responsible for helping pay for your medical care

However, there are times when your information may be shared without your permission. This happens when the local county JFS office, ODJFS, or ODM checks the information you give. For example, the local county JFS office may use your SSN when contacting other agencies or people to make sure that your information is correct and that you qualify for help.

To make sure your household is eligible and receives the correct amount and type of benefits (SNAP, Cash, etc.), federal, state, and local officials will check the information you provide. The State Income and Eligibility System, the Disqualified Recipient Subsystem, other computer matching systems, program reviews, and audits will also be used to check your information for eligibility purposes. Some information may also be sent to the U.S. Citizenship and Immigration Services (USCIS) to verify that it is correct. If you did not provide an SSN for some household members, their information will not be shared with USCIS.

ODJFS and ODM may share your information if:

- Your application for Medicaid is denied for being over income. It may be sent to the Federally Facilitated Marketplace (FFM) to determine if you qualify for other health insurance.
- Somebody calls a county JFS office asking for information about you. JFS must have either a signed *Release of Information Form (JFS Form 03741)* or a signed document from you indicating your Authorized Representative.
- They enter into a data-sharing agreement with other agencies. This will allow them to get or give out your household's SSNs, income, eligibility, or medical insurance information (called third-party liability).
- A court issues a subpoena for your case record. ODJFS and ODM will then share your information with the court. This can happen if you are under investigation, prosecution, or are charged with a civil or criminal crime related to benefits provided by ODJFS or ODM.
- You applied for multiple programs on your application. ODJFS and ODM will then share your information with those programs. This could include child support, the special supplemental nutrition program for women, infants, and children (WIC), and Help Me Grow (HMG).
- They need information from outside agencies to verify your eligibility for benefits. This information can be used as proof, so you won't have to provide certain documents yourself. These outside agencies include the U.S. Department of Health and Human Services (HHS), the Social Security Administration (SSA), the U.S. Department of the Treasury (USDT), the Ohio Department of Taxation (ODT), and the Ohio Department of Health (ODH).
- Your application is approved. ODFJS and ODM may then share details about child care authorizations for your child(ren) with the approved child care provider.

Personal Information (Continued)

It is important for you to know that ODJFS or ODM:

- Will not send you emails or text messages requesting your personal information or asking for your Personal Identification Number (PIN)
- Will not call you to ask for personal information that you already provided us
- Will not send you holiday greetings, public announcements, or political information (except voter registration materials)
- Will not share your data or information with companies or telemarketers
- Will provide you with voter registration information and materials when you apply or reapply for benefits, or when you report a change to your case
- May send you health and welfare information, such as free medical exams, availability of surplus food, and consumer protection information

Additional Information

Religious Agencies

Some county JFS offices have agreements with other agencies to provide services to families who may be receiving work support services through the PRC program, or to serve as work sites for parents receiving OWF Cash Assistance. Some of the services or work sites may be at religious organizations, such as churches. If you do not want to go to a religious organization for services or to work, let your county JFS office know.

Domestic Violence

Domestic violence is when you or someone in your household is hurt by a partner, spouse, boyfriend or girlfriend, a family member, or someone living in your home. This can include hitting, making threats, stalking and/or following you or preventing you from coming or going freely. All information you choose to share is confidential. You are not required to report domestic violence to your county JFS office, however, your county JFS office is required by law to report child abuse to the county public children services agency (PCSA).

Domestic Violence Resources

Ohio Domestic Violence Network:
Website: odvn.org
Phone: 800-934-9840

National Domestic Violence Network:
Website: thehotline.org
Phone: 800-799-7233 | TTY/TDD: 800-787-3224

Domestic Violence Waivers:

If you are unable to meet certain program requirements due to domestic violence, please contact your county JFS office for more information on how to receive a waiver. If the county JFS office grants your waiver request, you will not have to meet some program requirements while the waiver is in place.

- **Work:** You may be temporarily excused from your work requirement if it may put you or your children in danger of domestic violence, or if it interferes with your ability to escape the domestic violence.
- **Child Support:** You may be temporarily excused from cooperating with child support rules if your local Child Support Enforcement Agency (CSEA) determines that cooperation would not be in the best interests of the child or would make it more difficult for the caretaker or child to escape domestic violence. During this time, you will be excused from cooperating with the CSEA in establishing paternity or establishing/enforcing a support order.
- **Time Limits:** OWF Cash Assistance provides benefits to eligible families for up to 36 months. However, you may be eligible to receive benefits for longer than 36 months if losing them will put you or your children in danger of domestic violence or interfere with your ability to escape the domestic violence.

Civil Rights

Individuals eligible for, receiving services from, and/or benefiting from programs funded through ODJFS and ODM are protected by various laws, regulations, rules, and policies against unlawful discrimination on the basis of race, color, religion, disability, age, sex, national origin, political belief, political affiliation, and citizenship/participation status. Protected classes may vary depending on the program.

What is Discrimination?

Discrimination is an action, policy, or practice, that results in unequal and/or prejudicial treatment of people based on their race, religion, gender, age, sexual orientation, and/or other categories. Individuals within a protected class cannot be:

- Denied or delayed any service, aid, or other benefit provided by an ODJFS/ODM program due to their protected status
- Subjected to segregation or disparate treatment in an ODJFS/ODM program
- Given services in humiliating or embarrassing ways
- Provided services using different rules to decide who will get help Limited in the use of buildings, rooms, or other space in a way that denies them participation or access
- Denied access to a service because buildings or facilities are not physically accessible to those with disabilities or because there was no way to effectively communicate with the service provider

If you are denied or delayed equal service and you think it was because of your protected class, you may have been subjected to unlawful discrimination. There is a difference between lawful and unlawful denial or delay of benefits and/or services. Individuals may be denied benefits and/or services if they do not meet the eligibility requirements. This is not considered unlawful or discriminatory.

Note: Title VI of the Civil Rights Act of 1964 allows you to be asked for racial and ethnic information. You do not have to provide this information, however, giving this information will help ODJFS follow Federal Civil Rights law. If you do not want to provide this information, it will have no effect on your case.

Filing a Complaint

If you believe you have been delayed or denied services because of your age, sex, national origin, political belief, political affiliation, or citizenship/participation status (protected classes may vary depending on the program), **you must file your complaint within 180 days of the date of the incident or treatment.**

Questions on How to File a Complaint?

If you have questions about how to file a complaint, call the ODJFS Bureau of Civil Rights, toll-free, at 866-227-6353, email Civil_Rights@jfs.ohio.gov, or write to that office at the address shown below.

Complaints regarding incidents of alleged discrimination should be sent to:
The Ohio Department of Job and Family Services, Bureau of Civil Rights
30 E. Broad Street, 30th Floor
Columbus, Ohio 43215-3414

If you need free legal help or advice, call 866-LAW-OHIO (866-529-6446), toll-free, or search the Legal Aid directory at *ohiolegalhelp.org/find-your-legal-aid.*

Website: *jfs.ohio.gov/civilrights/complaint.stm*
Phone: 614-644-2703 or toll-free at 866-227-6353
Fax: 614-752-6381

Civil Rights (Continued)

ODJFS will review your complaint. If it is determined that discrimination occurred, the department will act to correct it. Because ODJFS programs may have different complaint jurisdictions, your complaint can be forwarded and/or you can contact the following offices directly:

The Ohio Department of Medicaid, Office of Human Resources, Employee Relations
P.O. Box 182709
Columbus, Ohio 43218-2709

Website: *medicaid.ohio.gov/families-and-individuals/coverage/already-covered/rights*
Email: *ODM_EEO_EmployeeRelations@medicaid.ohio.gov*

U.S. Department of Health and Human Services - Office for Civil Rights
200 Independence Ave SW
Washington, D.C. 20201

Website: *hhs.gov/ocr/complaints/index.html*
Phone: 877-696-6775

U.S. Department of Labor Civil Rights Center
200 Constitution Ave, Room N-4123
Washington, D.C. 20210

Website: *dol.gov/agencies/oasam/civil-rights-center/how-to-file-complaint*
Fax: 202-693-6500

People with Disabilities

All persons with disabilities are protected against unlawful discrimination by the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and similar state laws. You also are protected if you have a record of a medical or mental impairment, a combination of impairments, or if ODJFS, ODM, or your county JFS office has contracted with a private agency to help provide your benefits.

What is a Disability?

A disability is a physical or mental impairment, or a combination of impairments, that substantially limits one or more of your major life activities. A person is disabled if he or she is substantially limited in performing a major life activity compared to most people in the general population.

A major life activity includes, but is not limited to, the following: caring for yourself, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. It also includes major bodily functions, such as your immune system, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

Note: With the exception of eyeglasses or contact lenses, a person's disability should be determined whether or not medical care or a device will help them function well.

Who is a Qualified Individual with a Disability?

A qualified individual with a disability is someone who is applying or eligible for government benefits and services, such as SNAP or OWF Cash Assistance. ODJFS, your county JFS office, ODM, or an employer may have to make physical changes to allow you to access the agency's office or an assigned worksite. Or they may have to provide aids or special services (such as an interpreter, reader, or special equipment) to help you use the benefit or service or to communicate with them.

People with Disabilities (Continued)

Persons with disabilities who require alternative means of communication for program information (ex: Braille, large print, audiotape, American Sign Language, etc.), should contact the county JFS office (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

Accommodations

An agency or employer has a duty to reasonably accommodate your disability so you can take advantage of a program, benefit, or service. However, an accommodation may not be considered reasonable if it causes an undue financial or administrative burden or if it changes the fundamental nature of the program. Under any of these cases, the county JFS office or employer can refuse to make the accommodation. In addition, if you pose a "direct threat" to the health or safety of yourself or others, and if reasonable steps cannot remove the health or safety threat, you may not be able to participate in certain work activities. Any decision about whether you pose a direct threat will be made on an
individualized, case-by-case basis and cannot be based on prejudices, fears, stereotypes, or assumptions.

Reasonable Accommodations May Include the Following:

- Ensuring that communication services are available for those with limited hearing, sight, and/or speech
- Ensuring that the workplace and/or service location is accessible
- Reassigning or relocating classes and/or modifying existing class environments
- Restructuring training curricula, formats, or training hours
- Providing special equipment (ex: large-type fonts for computer monitors)
- Providing help with filling out applications and gathering documentation
- Providing additional explanations of program rules
- Providing an interpreter if you are deaf or hard of hearing
- Making special appointment accommodations, such as rescheduling; scheduling for a particular day, time or location; allowing someone to accompany you; holding phone appointments; allowing extra time; or allowing home visits
- Sending copies of notices to a third party, such as a relative, neighbor, or advocate
- Making reasonable changes to agency policies or practices, for example, allowing a blind person to bring a service animal
- Posting signs showing the location of wheelchair-accessible entrances, restrooms, elevators, and interior ramps

Note: The above accommodations are not intended to be all-inclusive. Every person with a disability is unique and has unique needs. If you need a reasonable accommodation, let your county JFS office know what works best for you.

You are also protected if you are associated with a person with a disability. For example, if you have a minor child with a disability who requires medical treatment, therapy, or hospitalization, any appointments or work assignments should accommodate your child's medical schedule.

Protecting Your Benefits

Make sure you are guarding your Ohio Direction Card and EPPICard™ to prevent yourself from being a victim of "card skimming." Card skimming is when thieves place a device on a retailer's card-swiping machine to copy your card information and steal your benefits. Card skimming can happen to anyone that uses a credit, debit, or EBT card, including an Ohio Direction Card and EPPICard™.

The following actions may help prevent you from becoming a victim of card skimming (continued):

- Keep your Personal Identification Number (PIN) a secret. Do not share your PIN with anyone outside your household. Cover the keypad when you enter your PIN on a card-swiping machine.
- Check your Ohio Benefits account regularly for unauthorized charges. If you notice any, change your PIN immediately to stop the thief from making any new purchases.

Protecting Your Benefits (Continued)

The following actions may help prevent you from becoming a victim of card skimming (continued):

- Check card reading machines to make sure there's nothing suspicious overlayed or attached to the card swiper or keypad. Overlays can be difficult to detect, but are often bigger than the original machine and may hide parts of it.
- Change your PIN monthly, before each scheduled benefit deposit, and/or after online purchases using your EBT card or cash card and PIN.
- Never share your EBT card or cash card number or PIN if you are asked for it through an email, text message, or phone call.

If you believe your benefits were stolen, change your Ohio Direction Card and EPPICard™ PIN right away, then ask for a new EBT card or cash card by calling 866-386-3071 for SNAP, or 866-320-8822 for cash cards. Notify your local county JFS office and file a theft report with your local law enforcement agency.
Contact information for your local county JFS office may be found at *jfs.ohio.gov/county*.

Helpful Resources

State of Ohio Resources

Children with Medical Handicaps
Website: *odh.ohio.gov/know-our-programs/children-with-medical-handicaps* | **Phone:** 614-466-1700

County JFS Offices
Website: *https://jfs.ohio.gov/about/local-agencies-directory*

Early Childhood Programs and Services for Ohio's Families and Children
Website: *boldbeginning.ohio.gov*

Help Me Grow
Website: *helpmegrow.ohio.gov* | **Phone:** 800-755-GROW (800-755-4769)

Imagination Library
Provides free monthly books for children in Ohio up to age 5. **Website:** *ohioimaginationlibrary.org*

Ohio's Best Rx:
Website: *rxresource.org/prescription-assistance/ohios-best-rx.html* | **Phone:** 866-923-7879

Ohio Department of Job and Family Services (ODJFS)
Website: *jfs.ohio.gov* | **Phone:** 866-ODJFS4U (866-635-3748)

Ohio Domestic Violence Network
Website: *odvn.org* | **Phone:** 800-934-9840

Ohio Government
Website: *ohio.gov* | **Phone:** 614-466-2000

Register to Vote
Website: *olvr.ohiosos.gov* | **Phone:** 877-767-6446

Search for Early Care and Education Programs
Website: *childcaresearch.ohio.gov* | **Phone:** 877-302-2347

SNAP, Cash, Medicaid, and/or Child Care Assistance: Apply Online or Report Changes
Websites: *benefits.ohio.gov*; *medicaid.ohio.gov* | **Phone:** 844-640-6446

Step Up To Quality (SUTQ): Ohio's Child Care Quality Rating System
Website: *https://jfs.ohio.gov/child-care/step-up-to-quality*

Unemployment Benefits
Website: *unemployment.ohio.gov*
Phone: 877-OHIOJOB (877-644-6562)

Women, Infants and Children (WIC)
Website: *odh.ohio.gov/know-our-programs/Women-Infants-Children* | **Phone:** 844-601-6881

Program Information Resources

Medicaid Consumer Hotline
Website: *medicaid.ohio.gov* | **Phone:** 800-324-8680

Medicare
Website: *medicare.gov* | **Phone:** 800-MEDICARE (800-633-4227)

Social Security Administration
Website: *ssa.gov* | **Phone:** 800-772-1213

Department of Job & Family Services

Mike DeWine, Governor
State of Ohio

Matt Damschroder, Director
Ohio Department of Job and Family Services

Department of Medicaid

Mike DeWine, Governor
State of Ohio

Maureen Corcoran, Director
Ohio Department of Medicaid

Department of Children & Youth

Mike DeWine, Governor
State of Ohio

Kara Wente, Director
Ohio Department of Children and Youth

JFS 07501 (Rev. 3/2024)

Department of Job & Family Services

NOTICE TO INDIVIDUALS APPLYING FOR OR PARTICIPATING IN OHIO WORKS FIRST (OWF) REGARDING COOPERATION WITH THE CHILD SUPPORT ENFORCEMENT AGENCY (CSEA)

You are required, as a condition of your eligibility for OWF, to cooperate with the Child Support Enforcement Agency (CSEA) in establishing paternity or in securing support from the absent parent(s).

Your Cooperation is Needed

In cooperating with the CSEA, you may be asked to do one or more of the following:

- Name the parent of any child applying for or participating in OWF;
- Give information you have to help locate the absent parent;
- Help determine legally who the father is;
- Help to obtain support payments due you or your child(ren);
- Come to the CSEA or court, if necessary, to give information about the parent of your child(ren).

Child support cooperation is a provision in your Self Sufficiency Contract (JFS Form 03801). When you or any member of your assistance group fail or refuse to cooperate with the CSEA, you will be subject to the following sanction criteria:

- First failure or refusal results in termination of your OWF for one month;
- Second failure or refusal results in termination of your OWF for three months;
- Third or more failure(s) results in termination of your OWF for six months.

Benefits of Cooperating

Your cooperation with the CSEA might result in the following benefits to your child(ren):

- Finding the absent parent
- Legally establishing your child(ren)'s paternity
- Establishing a child(ren) support order for your child(ren)
- Enforcing the child(ren) support order
- Receiving support payments higher than your public assistance grant
- Obtaining rights for your child(ren) to receive future benefits (ex: Social Security, Veterans', etc.)

Good Cause: What is Considered a Valid Reason for Not Cooperating?

If cooperating with the CSEA would not be in the best interests of the child(ren), or would make it more difficult for you or the child(ren) to escape domestic violence, you may ask for a Good Cause Waiver. If you are granted a Good Cause Waiver, you will not have to cooperate with the CSEA.

Reasons for Requesting a Good Cause Waiver

You may request a Good Cause Waiver when:

- You are or the child(ren) is being subjected to domestic violence and cooperation would not be in the best interests of the child(ren) or would make it more difficult for you or the child(ren) to escape domestic violence;
- Legal adoption proceedings for the child(ren) are pending before a court and cooperation would not be in the best interests of the child(ren);
- Adoption of the child(ren) is under active consideration and cooperation would not be in the best interests of the child(ren); or
- The child(ren) was conceived as a result of incest or rape and cooperation would not be in the best interests of the child(ren).

Written Documentation

You must provide written documentation within 45 days of requesting a Good Cause Waiver to the CSEA so they can determine whether you have good cause for refusing to cooperate.

Written documentation is acceptable from any one of the following:

- Anyone whom you have sought assistance from, such as a governmental entity (police, courts, or other local agencies), shelters, legal, religious, medical, and/or other professionals who have knowledge of the domestic violence, if it is your reason for claiming good cause.
- A court, attorney, child protective services agency, or social services agency that indicates that legal adoption proceedings for the child(ren) are pending before a court, or if adoption of the child(ren) is under active consideration, and cooperation would not be in their best interests.
- A medical professional, law enforcement agency, or vital records agency verifies that the child(ren) was conceived as a result of incest or rape, and cooperation would not be in the best interests of the child(ren).

Note: If your reason for claiming good cause is that you or the child(ren) is/are **being subjected to domestic violence** and you cannot obtain written documentation, the CSEA can accept a written statement from you.

Please CHECK the boxes that apply to you, and SIGN at the bottom of the page:

☐ I have read, or have had read to me, and understand the statement concerning my right to claim good cause for refusing to cooperate with the CSEA. **(Required)**

☐ I want to ask the CSEA for a Good Cause Waiver. **If you check this box,** please fill out the blanks below:

Printed Full Name of Individual Requesting Good Cause Waiver	Case/Cat/Seq

To help protect your safety, do you want **all letters and correspondence about domestic violence** to be sent to a **different address** and/or would you like to be called at a **different phone number?**

☐ **No - I do not want these correspondence sent to a different address** or to be called at a different phone number.

☐ **Yes - I would like these correspondence sent to an alternate address and/or to be contacted at a different phone number.** If so, please put the alternate contact information below.

Street Address
City/State/Zip Code
Alternate Phone Number *(include area code)*

Signature of Applicant/Participant	**Date**
Signature of Worker	Date

Ohio Department of Medicaid

OHIO MEDICAID ESTATE RECOVERY

What is estate recovery?

Estate recovery seeks to obtain repayment for the cost of Medicaid benefits once a Medicaid eligible individual is deceased. This happens after the death of a Medicaid individual who was either permanently institutionalized or age 55 and older.

What is an estate?

An estate is all of the real and personal property owned by a Medicaid individual at the time of death, whether or not it passed through probate court.

What Medicaid benefits are subject to estate recovery?

Medicaid payments for services received since January 1995 are subject to estate recovery. Medicare premium assistance payments made after January 1, 2010, are subject to recovery only when the Medicaid individual was permanently institutionalized.

How does estate recovery work?

The estate's executor is responsible for notifying the Ohio Attorney General's Office (AGO) of a Medicaid individual's death, if the individual was permanently institutionalized or age 55 or older. Once the AGO has been notified, the AGO will present a claim to the estate.

When does estate recovery take place?

Recovery from the estate will only be made:

- After the death of the Medicaid individual's surviving spouse.
- When the deceased Medicaid individual has no surviving child younger than age 21.
- When the deceased Medicaid individual has no surviving child of any age who is considered blind or disabled under Medicaid regulations.

Does a will protect assets from estate recovery?

No. Ohio's Medicaid program and other creditors are paid before any assets are distributed to heirs or other beneficiaries.

Are there exceptions to estate recovery?

If there is an undue hardship to a survivor, the right to immediate recovery may be delayed or waived. Undue hardship is determined on a case-by-case basis.

Is a person's house subject to estate recovery?

Yes. A Medicaid individual's house may be subject to estate recovery. If the Medicaid eligible individual was permanently institutionalized, any claim from the sale of a house may be delayed while the individual's sibling or child resides in the home, if specific conditions are met.

Will the Attorney General's Office contact the family of the deceased?

After a Medicaid individual dies, the AGO will send a notice of claim to the estate's executor requesting repayment for the cost of Medicaid benefits. It is the estate executor's responsibility to notify any family members or other heirs who might be affected by the estate recovery. If the estate executor has not been identified to the AGO, the AGO may need to contact the Medicaid individual's family members.

How can the Attorney General's Office be reached?

The Medicaid Estate Recovery Unit of the AGO can be contacted at:

Medicaid Estate Recovery Unit
30 E. Broad Street, 14th Floor
Columbus, Ohio 43215-3130

Information can be obtained online at http://www.ohioattorneygeneral.gov/Business/Collections or by calling the Ohio Medicaid Consumer Hotline at 1-800-324-8680, or by calling your local County Department of Job & Family Services.

Instructions to CDJFS: In Journal Notes, record the date that this form was given or mailed to the consumer.