Ohio
Medicaid Renewal Form

Notice Date:
Respond By
Letter Number:

Questions? Ask your worker.

TDD - For the Hearing Impaired: _____

County Phone: _____

Office Hours: 9AM-5PM

It is time to renew your Medicaid coverage.

You can renew your Medicaid in any one of these ways

- **Renewing online is faster!** If you applied online, go to **benefits.ohio.gov** and click on Renew My Benefits.
- **By mail:** Complete this form and mail it to your local county department of job and family services. Find the address to your local office here: **jfs.ohio.gov/county/county_directory.pdf**
- **In person:** Visit your local county office. Find the address at the link above.

How to complete this renewal form

1. Answer all of the questions on the form.
2. Add any missing information. If any information has changed, write in the new information.
3. Sign the form on page 9. If there is anywhere in this form where you need to provide additional information for yourself or a household member, please print additional copies of Attachment A or write the additional information on a separate sheet of paper and attach it to this form.
4. **Return this form by** . If you do not return the form by this deadline, you will lose your Medicaid coverage.

What we need

We need information about each person living in your household or listed on your tax return, including:

- employer and income information for everyone in your family. For example: information from pay stubs, W-2 forms, or wage and tax statements, ***and***
- policy numbers for any current health insurance.

We will check your answers using information from computer data sources, including the Internal Revenue Services (IRS),the Social Security Administration, the Department of Homeland Security and others. If the information does not match, we may ask you to send more information.

If you do not qualify for Medicaid

If you do not qualify for Medicaid, the Ohio Department of Medicaid (ODM) will check to see if you qualify for other kinds of health coverage. We may send your information to another program so they can see if you qualify.

What happens next?

We will process your renewal form. If you don't have all the information we ask for, sign and submit your application anyway. We will follow up with you within 1-2 weeks. If you do not hear from us, call (800) 324-8680.

? **NEED HELP WITH YOUR FORM?** Visit benefits.Ohio.gov or HealthCare.gov or call us at **(800) 324-8680**. Para obtener una copia de este formulario en Espanol, 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.

1 Your contact information

Review your contact information here.	Correct any wrong or missing information here.
	Name *(first, middle, last & suffix)*
Home Address:	**Home** Address — Apartment #
	City (*home*) — State — Zip code
Mailing Address:	**Mailing** Address — Apartment #
	City (*mailing*) — State — Zip code
Phone:	Best phone number to reach you: ☐Home ☐Cell ☐Work
Other:	Number:
	Other phone number, if you have one: ☐Home ☐Cell ☐Work
	Number:

Email Address: ☐ I want to receive information by email

Voter Registration Application Attached - Help completing this form is available if you need it.
If you are not registered to vote where you live now, would you like to apply to register to vote today? If you do not check either box, you will be considered to have decided not to register to vote at this time.

☐ YES, I want to register. ☐ NO, I do not want to register to vote.

For which programs would you like to apply?

☐ 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

2 We need information about who files tax returns.

You can still renew if you do not file tax returns.

Will anyone in the household file a **federal tax return *next year*** to report income earned ***this year***?

☐ Yes ***If yes,*** answer all of the questions below. ☐ No ***If no,*** answer the question marked with a star * below

Person 1: Name (*first, middle, last & suffix*)

If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

Person 2: Name (*first, middle, last & suffix*)

This is for a second tax filer in the household
If this person is filling a joint return, write the name of the spouse:

Is this person will claim dependents, write the names of the dependents:

* If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents. Answer only if different than what you reported above or if you did not fill in any information above.

Name of tax filer: _____

Name of dependents: _____

3 These are the people in your household who get Medicaid and need to renew now

Person 1:

☐ Ohio Medicaid **has** this person's Social Security number.

☐ Ohio Medicaid **does not** have this person's Social Security number. ***Write it in the spaces below.***
___-___-____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because Ohio Medicaid has it.

Alien ID: _____ Document Type: _____

Person 2:

Relationship to Person 1:

☐ Ohio Medicaid **has** this person's Social Security number.

☐ Ohio Medicaid **does not** have this person's Social Security number. ***Write it in the spaces below.***
___-___-____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because Ohio Medicaid has it.

Alien ID: _____ Document Type: _____

Person 3:

Relationship to Person 1:

☐ Ohio Medicaid **has** this person's Social Security number.

☐ Ohio Medicaid **does not** have this person's Social Security number. ***Write it in the spaces below.***
___-___-____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because Ohio Medicaid has it.

Alien ID: _____ Document Type: _____

Person 4:

Relationship to Person 1:

☐ Ohio Medicaid **has** this person's Social Security number.

☐ Ohio Medicaid **does not** have this person's Social Security number. ***Write it in the spaces below.***
___-___-____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because Ohio Medicaid has it.

Alien ID: _____ Document Type: _____

Person 5:

Relationship to Person 1:

☐ Ohio Medicaid **has** this person's Social Security number.

☐ Ohio Medicaid **does not** have this person's Social Security number. ***Write it in the spaces below.***
___-___-____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because Ohio Medicaid has it.

Alien ID: _____ Document Type: _____

4 We need more information about people not listed in Section 3 *(page 3)*

Tell us about anybody else in your household or on your tax return.

Other person: Name (*first, middle, last & suffix*):

☐ Ohio Medicaid **has** this person's Social Security number.

☐ Ohio Medicaid **does not** have this person's Social Security number. ***Write it here*** if this person is applying for health insurance coverage:

___ ___ ___ - ___ ___ - ___ ___ ___ ___

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

☐ Check here if this person is no longer living in the household.

Date of birth (month/ day/ year):

This person is: ☐ Male ☐ Female

How is this person related to you?

☐ Check here if this person **has** Medicaid.

☐ Check here if this person wants health insurance coverage. Please fill out Attachment A on page 10.

Other person: Name (*first, middle, last & suffix*):

☐ Ohio Medicaid **has** this person's Social Security number.

☐ Ohio Medicaid **does not** have this person's Social Security number. ***Write it here*** if this person is applying for health insurance coverage:

___ ___ ___ - ___ ___ - ___ ___ ___ ___

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

☐ Check here if this person is no longer living in the household.

Date of birth (month/ day/ year):

This person is: ☐ Male ☐ Female

How is this person related to you?

☐ Check here if this person **has** Medicaid.

☐ Check here if this person wants health insurance coverage. Please fill out Attachment A on page 10.

Other person: Name (*first, middle, last & suffix*):

☐ Ohio Medicaid **has** this person's Social Security number.

☐ Ohio Medicaid **does not** have this person's Social Security number. ***Write it here*** if this person is applying for health insurance coverage:

___ ___ ___ - ___ ___ - ___ ___ ___ ___

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

☐ Check here if this person is no longer living in the household.

Date of birth (month/ day/ year):

This person is: ☐ Male ☐ Female

How is this person related to you?

☐ Check here if this person **has** Medicaid.

☐ Check here if this person wants health insurance coverage. Please fill out Attachment A on page 10.

5 Tell us about *other* health insurance coverage people have

Include anyone in Section 3 and 4 with Medicaid and anyone who is applying for health insurance coverage.

Name of insurance company:

Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance ____________

List everyone who is on this policy:

☐ Check here if this is a limited benefit policy

Name of insurance company:

Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance ____________

List everyone who is on this policy:

☐ Check here if this is a limited benefit policy

☐ **Check here if anyone on this form is offered health insurance through a job, even if they are not enrolled.**
Tell us who. Name: ________________________________

6 Tell us more about the people listed on this form

If anyone listed on this form (whether renewing or applying for health coverage or not) is pregnant, write her information below.

Name (*first, middle, last & suffix*):	How many babies are expected?	Due Date:
Name (*first, middle, last & suffix*):	How many babies are expected?	Due Date:

If anyone who is renewing or applying for health coverage is between the ages of 18 and 26 and was in foster care at age 18, write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

If anyone who is renewing or applying for insurance coverage is blind or disabled, write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

If anyone who is renewing or applying for health coverage has a medical, mental health, or substance use condition that limits his or her ability to work, go to school, or take care of daily activities (like bathing or dressing), write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

If anyone who is renewing or applying for health coverage lives in a long term care facility, group home, or nursing home, or regularly gets medical care, personal care, or health services at home or in another community setting (like adult day care), write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

If anyone who is renewing or applying for health coverage is between the ages of 18 and 22 and is also a full-time student, write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

☐ **Check here if anyone who is renewing or applying for health insurance coverage is an American Indian or Alaska Native, and fill out Attachment B on page 11.**

7 Tell us about work

Fill in the information below for everyone in your household or on your tax return who has income from a job (**not** self-employed) whether or not they are renewing or applying for coverage. If someone has more than one job, tell us about **all jobs.** You can tell us about **self-employment** on the next page. *Make a copy of this page if you need space for more jobs or people. Cross out any information that is* ***not correct*** *about the members of your household. Write in any new information.*

Job 1: Name of the person who is working (*first, middle, last & suffix*):

Employer name: | **Employer** phone number:

Employer address:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? **$**

Average hours worked each week:

Job 2: Name of the person who is working (*first, middle, last & suffix*):

Employer name: | **Employer** phone number:

Employer address:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? **$**

Average hours worked each week:

Job 3: Name of the person who is working (*first, middle, last & suffix*):

Employer name: | **Employer** phone number:

Employer address:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? **$**

Average hours worked each week:

Job 4: Name of the person who is working (*first, middle, last & suffix*):

Employer name: | **Employer** phone number:

Employer address:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? **$**

Average hours worked each week:

Job 5: Name of the person who is working (*first, middle, last & suffix*):

Employer name: | **Employer** phone number:

Employer address:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? **$**

Average hours worked each week:

Section 7 continued on next page **> > >**

7 Tell us about work *(continued)*

List anyone in your household who has changed jobs or has worked fewer hours in the past four months.

1. Name (*first, middle, last & suffix*):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

2. Name (*first, middle, last & suffix*):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

If anyone in your household is **self-employed**, we need to know about their work.
See the instructions for more information about deductions.

1. Name (*first, middle, last & suffix*):

Type of work:

How much net income will this person get from self-employment this month? Amount: **$**

2. Name (*first, middle, last & suffix*):

Type of work:

How much net income will this person get from self-employment this month? Amount: **$**

Subtract the expenses below from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fridge benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to self-employed SEP, SIMPLE, or qualified retirement plan

8 Tell us about other income

*Cross out any information that is **not correct** about members of your household. Write in any new information.*

Unemployment **How much?** **How often?**

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Social Security **How much?** **How often?**

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Pensions **How much?** **How often?**

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Retirement accounts **How much?** **How often?**

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Section 8 continued on next page **> > >**

8 Tell us about other income *(continued)*

*Cross out any information that is **not correct** about members of your household. Write in any new information.*

Alimony received — How much? How often?

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Farming or fishing (*profit after business expenses*) — How much? How often?

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Rental income or royalties (*profit after business expenses*) — How much? How often?

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Other income Type: — How much? How often?

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Other income Type: — How much? How often?

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

If anyone in your household has **tax deductions**, tell us what kind.

Alimony paid to someone else — How much? How often?

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Student loan interest paid — How much? How often?

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

Other deductions — How much? How often?

Name (*first, middle, last & suffix*): $ ☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other

List the names of anyone whose income **changes** from month to month. Also tell us how much you think their income will be for the year. *Make a copy of this page if you need space for more people.*

1. Name (*first, middle, last & suffix*):

What do you expect his or her income to be **this year**? Amount: $ ☐ Check here if you do not know what the income will be **this year.**

2. Name (*first, middle, last & suffix*):

What do you expect his or her income to be **this year**? Amount: $ ☐ Check here if you do not know what the income will be **this year.**

3. Name (*first, middle, last & suffix*):

What do you expect his or her income to be **this year**? Amount: $ ☐ Check here if you do not know what the income will be **this year.**

9 Read and sign this application

Renewal of coverage in future years

Read the statement below and check **one** box.
To make it easier to check my income at renewal time, I give permission to the Ohio Department of Medicaid to use income information from my tax returns for the number of years I checked below.

I understand that the Ohio Department of Medicaid will send the information they have. I will have a chance to correct and update this information. I can also change my mind and now allow the Ohio Department of Medicaid to check this information.

Yes, I give permission to check my income on tax returns for (check one box):

☐ 5 years (the longest time) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, I do not give permission to use my tax returns.

Your rights and responsibilities

- I am signing this renewal form 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 (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.

If anyone on this application is eligible for Medicaid

- I am giving to the Ohio Department of Medicaid our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medical agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this renewal form 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 and 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 previously mentioned departments to exchange any information I have provided on this form, to enable the departments to determine my eligibility.
- I understand that if I do not qualify for Medicaid, Ohio Department of Medicaid will check to see if I qualify for other kinds of health coverage.Ohio Department of Medicaid may send my information to another program so they can see if I qualify. The Ohio Department of Medicaid will check my answers using information from computer data sources, including the Internal Revenue Services (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, Ohio Department of Medicaid may ask me to send more information.
- I understand that, after my death, Ohio Department of Medicaid can file a claim against my estate to recover money that the state paid for coverage provided to me. This process must happen if I am in a medical institution and not expected to return home, or if I am 55 years of age or older and the state pays for my nursing facility services, home and community based services, or related hospital and prescription drug services. The amount recovered by the Ohio Department of Medicaid will not be more than the amount Medicaid paid for my care.
- I understand that when I send in the form, it means I have permission from everyone whose information is on the form to submit their information to Ohio Department of Medicaid and receive any communications about their eligibility and enrollment.
- I understand that Ohio Department of Medicaid is authorized to collect information on this form, and other supporting information including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (Public Law 111-152) and the Social Security Act.

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 and date below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment C on page 12.

☐ Check here if you are an authorized representative. Sign below and fill out Attachment C on page 12

Signature of household contact or authorized representative:	Date:

Attachment A

If you need to add more than one person, please copy this page first.

ADDITIONAL PERSON _____ (give this person a number)

Complete Attachment A 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 heath coverage and have a 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 question 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
☐ Asian Indian ☐ Black or African American ☐ Japanese ☐ Other Asian ☐ Samoan
☐ Korean ☐ Other Pacific Islander ☐ Chinese ☐ Native Hawaiian ☐ Other _____

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

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 Supplement 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. **Deduction:** 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.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ 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):
$ _____

Attachment B Assistance with completing this renewal form

You can give a trusted person permission to talk about this renewal form with us, see your information, and act for you on matters related to this form, including getting information about your renewal and signing your form 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 this form.

If you have an authorized representative now, please answer these questions.

We show that you chose this person as your authorized representative:

Do you still want this person to be your authorized representative

☐ Yes ☐ No

If yes, has any of his or her information changes?

☐ Yes ☐ No

If your authorized representative's information has **changed**, or if you would like a **different** authorized representative, please write the new information here:

Name of authorized representative:

Address: Apartment # City State Zip code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: Date:

If you do not have an authorized representative and want one, please answer these questions.

☐ Check here if you want an authorized representative. Answer the questions below.

Name of authorized representative:

Address: Apartment # City State Zip code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: Date:

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 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 intent 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's driver license, you must provide 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 intent 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 intent 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

ODM XXXX4

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).