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: **http://medicaid.ohio.gov/FOROHIOANS/AlreadyCovered/NoticeofPrivacyPractices.aspx**

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

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	☐ 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

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 con.rm 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

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.

RESOURCE QUESTIONNAIRE

Is anyone applying in need of: Nursing Home Care? YES _____ NO _____

Are you currently residing in a Nursing Home? YES _____ NO _____

Is anyone applying in need of: In-Home Care/ Waiver Services? YES _____ NO _____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS - PLEASE GIVE US THE NAME WHO NEEDS THE ABOVE SERVICES. _____

DO YOU OR ANYONE IN THE HOUSEHOLD OWN IN ANY OF FOLLOWING:

Vehicle	YES _____	NO _____
Saving Account	YES _____	NO _____
Checking Account	YES _____	NO _____
CD's	YES _____	NO _____
401K	YES _____	NO _____
Deferred Compensation	YES _____	NO _____
Stock	YES _____	NO _____
Savings Bonds	YES _____	NO _____
Christmas Club	YES _____	NO _____
Mutual Funds	YES _____	NO _____
IRA	YES _____	NO _____
Trust Fund	YES _____	NO _____
Cemetery Lot	YES _____	NO _____
Prepaid Burial Contract with Funeral Home	YES _____	NO _____
Life Insurance	YES _____	NO _____
Annuity	YES _____	NO _____
Real Estate (including where you reside)	YES _____	NO _____
Mobile Home	YES _____	NO _____

CASH ON HAND, NOT IN BANK ACCOUNTS $_____

Have you or anyone applying, transferred/sold/given away any of the above mentioned assets in the last 5 years? YES _____ NO _____

Do you pay a premium for Health Insurance? YES _____ NO _____

Please provide verification of any/all items you answered YES.

13183 State Route 13, Millfield, Ohio 45761-9901
(740) 797-2523 1-800-762-3775
http://jfs.athensoh.org
COMMISSIONERS: Lenny Eliason, Charlie Adkins, Chris Chmiel
EXECUTIVE DIRECTOR: Scott Zielinski
An Equal Opportunity Employer Service Provider

Ohio Benefits Electronic Income and Asset Verification Acknowledgement Form

To determine eligibility for medicaid, Athens County Job and Family Services utilizes electronic database verification to verify information for applicants. This information consists of INCOME (Employment, Social Security, Unemployment, etc) and FINANCIAL RESOURCES (bank accounts, CDs, burial accounts, Annuities, etc). Please read and sign below, indicating whether you authorize, or refuse to authorize, Athens County Job and Family Services to check our electronic databases from financial institutions, as well as the federal data hub for income verification, for purposes of determining eligibility for medical assistance.
Please make sure to indicate your preference for BOTH Financial Resources and Income

Authorization Granted

☐ I authorize Athens County JFS to obtain information about **FINANCIAL RESOURCES** from banks, credit unions, or other financial institutions, through electronic verification, in order to determine eligibility for medical assistance.

☐ I authorize Athens County JFS to obtain information about **INCOME**, through electronic verification, in order to determine eligibility for medical assistance.

My authorization to obtain this information remains in effect until:

- My application for medical assistance is denied; or
- My eligibility for medical assistance ends; or
- I inform the county in writing that I wish to end my authorization

Authorization Refused

☐ I refuse to authorize Athens County JFS to obtain information about **FINANCIAL RESOURCES** from financial institutions, to determine eligibility for medical assistance.

☐ I refuse to authorize Athens County JFS to obtain information about **INCOME** from the Federal Data Hub, to determine eligibility for medical assistance.

I understand that by refusing to authorize Athens County JFS to utilize income and resource electronic verification, that it is my responsibility to provide verification of any information needed to determine my eligibility for medicaid, and that not providing this information may result in medical assistance being denied or discontinued.

Primary Applicant (or Authorized Representative) _____
PRINTED NAME

Primary Applicant (or Authorized Representative) _____
SIGNATURE

DATE SIGNED _____

Additional Adult HH Members

Applicant PRINTED NAME _____

Applicant SIGNATURE _____

Applicant PRINTED NAME _____

Applicant SIGNATURE _____

Applicant PRINTED NAME _____

Applicant SIGNATURE _____

Applicant PRINTED NAME _____

Applicant SIGNATURE _____

These questions are mandatory questions that must be answered in order to determine eligibility for Medicaid assistance. Please answer these questions for each ADULT member of the household, and attach to the application.

Case Name: _____ SSN of Applicant:_____

	Name / Person 1	Name / Person 2	Name / Person 3	Name / Person 4	Name / Person 5	Name / Person 6
Does this person expect to file taxes?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If the answer was **YES:**						
How will you file?	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate
Who do you claim as a dependent, if any?						
Does anyone claim YOU as a dependent?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If the answer was **NO:**						
Will you be claimed as a dependent?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
By whom?						
Do you have 3rd Party Ins?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If **YES,**						
Insurance Company:						
Type of Coverage:						

Ohio | Department of Job and Family Services

TO STRENGTHEN OHIO FAMILIES WITH SOLUTIONS TO TEMPORARY CHALLENGES

Program Enrollment & Benefit Information

Ohio | Department of Job and Family Services

Program Enrollment & Benefit Information

Overview

This booklet contains valuable information about many programs offered through county departments of job and family services. It explains how to apply for programs, what information you must provide when you apply, and what to do if you disagree with decisions made about your eligibility. It also talks about:

- Your right to be treated fairly.
- Your rights and responsibilities as a consumer.

The last three pages of this booklet contain perforated forms that you may want to tear out and use:

- The JFS 07105—Application/Reapplication Verification Request Checklist—This shows the verifications your county agency may request when you apply or reapply for benefits.
- The JFS 04196—Food Assistance Change Reporting Form—You may use this form to report a change if you are receiving Food Assistance.
- The JFS 07092—Notice to Individuals Applying for or Participating in Ohio Works First Regarding Cooperation with the Child Support Enforcement Agency—You must sign and return this form if you are applying for or receiving Ohio Works First cash assistance.

What types of help do county departments of job and family services offer?

County departments of job and family services can help with:

- Cash assistance
- Child care
- Child support
- Food assistance, also known as Supplemental Nutrition Assistance Program (SNAP) benefits
- Medicaid

Local agencies in each county manage these programs. These agencies include:

- The county department of job and family services (CDJFS). Some people call this the welfare department.
- The county public children services agency (PCSA). Some people call this the children services board.
- The county child support enforcement agency (CSEA).

In some counties, the PCSA or CSEA is part of the CDJFS.

You have the right to apply for help from these county agencies. The county agency will decide what help you can get, based on state and federal law, and will arrange for you to receive that help.

What other services are available?

Other supportive services available through county agencies are:

- Employment services, such as training and help finding a job
- Unemployment Compensation
- Work support services through the Prevention, Retention and Contingency (PRC) program
- Foster care and adoption assistance
- Learning, Earning and Parenting (LEAP) services
- Refugee resettlement services, such as employment assistance and health screening
- Other social services

Application Process—How do I apply for help?

For Cash Food and Medical Assistance

- You can apply online any time at **odjfsbenefits.ohio.gov**.
- Or, you can fill out a "Request for Cash, Food and Medical Assistance" (JFS 07200) form and submit it to your county agency by mail, in person or by fax.
- You may also file the application through your local Ohio Benefit Bank site. The Ohio Benefit Bank helps low- and moderate-income Ohioans apply for work supports such as tax credits and public benefits, including Ohio Works First, Food Assistance and Medicaid. To find the Ohio Benefit Bank site nearest you and to get more information, go to **ohiobenefits.org** or call 1-800-648-1176.

For Medicaid:

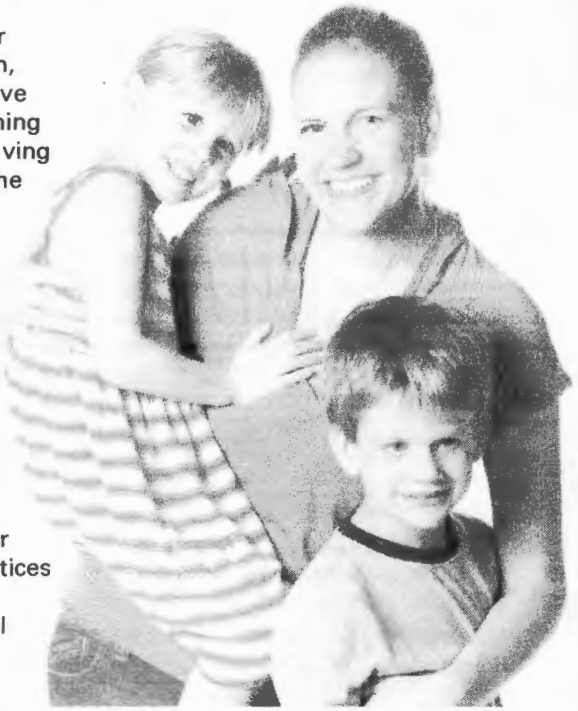
- o You can apply online anytime at **benefits.ohio.gov**.
- o You can call the Medicaid Consumer Hotline at 1-800-324-8680 to request an application or to apply by phone.
- o You can fill out an "Application for Health Coverage & Help Paying Costs" (ODM 07216), available at **medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM07216.pdf**.
- o Or, you can get help in person at local clinics or hospitals.

Fill out as much of the application as you possibly can. You can have a friend or relative help you fill out the application. You can also get help at your county agency. After you sign and date the application, you can submit it, even if you have to collect other information. Signing the application means you are giving true and correct information to the best of your knowledge.

Your caseworker has 30 days to make a decision about your case. Some households may qualify for their food assistance applications to be processed within 24 hours or seven days based on the household circumstances. You will receive an eligibility determination notice after the county agency has reviewed your application. Please review the notices carefully. Each letter will contain contact information for your local office if you have any questions.

How do I find my county office?

You can find the address and phone number of your county agency at **jfs.ohio.gov/County** or by looking in the county government section of your phone book. Some county agencies have multiple locations so make sure to call first to find the location nearest you. County agency hours may vary.



Domestic Violence

Domestic violence is when someone in your household is hurt by someone who is or was a partner, spouse, boyfriend or girlfriend, or a part of your household or family. Domestic violence includes hitting, hurting, threatening, or making you afraid by following you or preventing you from moving around freely. You are not required to report domestic violence to your county department of job and family services. Any information you choose to share is confidential. However, the county agency is required by law to report child abuse to the county public children services agency. In addition, you can receive free confidential help by calling the Ohio Domestic Violence Network at 1-800-934-9840.

What are domestic violence waivers?

If you are eligible for Ohio Works First or Food Assistance and you are a victim of domestic violence, some program requirements can be waived temporarily, which means they won't apply to you while the waiver is in effect.

- *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 or enforcing a support order.
- *Time Limits:* Ohio Works First provides cash assistance to eligible families for up to 36 months. However, you may be eligible to receive that assistance longer than 36 months if losing it will put you or your children in danger of domestic violence or interfere with your ability to escape the domestic violence.

Frequently Asked Questions (FAQs) about Applying

What if I need help applying for services?

If you are unable to complete the form by yourself, you may need someone to be your authorized representative. An authorized representative is a person who has your permission to apply for benefits for you. You can name your husband or wife, a relative or a friend you trust. You can also name a lawyer or a hospital social worker, but you don't have to. You must name this person in writing. Include what duties you want your authorized representative to take care of for you.

You can change your authorized representative at any time. Your authorized representative must be 18 or older.

What if I have a communication disability?

Those who are deaf, hard-of-hearing, blind or speech-disabled may use a TTY/TDD telephone to contact the Ohio Relay Service at 1-800-750-0750. Be sure to have the telephone number of the agency you wish to call ready, so that someone at the Relay Service can help you. For questions, comments, problems or complaints about the Ohio Relay Service, call 1-800-325-2223 (TTY/TDD and Voice).

What if English is not my primary language?

If English is not your primary language, you can receive interpretation and translation services. Ask your county contact for help. Your county contact can provide information to you in your language (either verbally or in writing).

What happens after I turn in my application?

After you turn in your form, you may need to have an interview with the local agency. This might need to be in person, or it could take place over the phone. If you submitted your application by mail, fax or email, the agency will tell you when your interview is scheduled. During your interview, the case worker will tell you if you need to provide any additional items, such as a birth certificate, proof of citizenship or proof of your address. The case worker will tell you about the help you are trying to get. He or she will also tell you what you must do to get that help.

If you don't need an interview, the agency will review your application to make sure it is completed, signed and dated. The county agency may send a letter to you (or your authorized representative) asking for more information in order to make a decision about your benefits. If the agency asks you for more information, try to return it right away. If you have trouble getting the information, ask the agency for help.

Every six or 12 months a review will be completed on your case. A case worker will contact you to determine if any of your information has changed. In addition, you will be required to report certain changes if they occur. For more information, see "Rights and Responsibilities" on page 5.

Who can help me if I have a problem or a question?

Any time you have a problem or a question, contact your county agency. If you still have problems or questions, you can contact the Ohio Department of Job and Family Services (ODJFS) directly at 1-866-ODJFS4U (1-866-635-3748). If you have questions about Medicaid, or if you need help completing an application for Medicaid, call the Ohio Medicaid Consumer Hotline at 1-800-324-8680.

The Ohio Benefit Bank also can help you apply for a number of benefits, including Ohio Works First, Food Assistance and Medicaid. Visit **ohiobenefits.org** for more information.

Food assistance is issued on the Ohio Direction Card; cash assistance is issued on the EPPICard™. If you have not previously had a card, you will receive one in the mail. If you previously had a card but no longer have it, or if your card does not arrive in the mail, call (866) 386-3071 for the Ohio Direction Card or (866) 320-8822 for the EPPICard™.

How does the agency use my personal information?

The information you give your county agency is private and will be kept confidential and secure. Your information may be viewed only by agency staff actively handling your case or participating in a quality control review. Without your permission, the agency cannot share the following information:

- Names and addresses
- Medical services provided
- Social and economic conditions or circumstances
- Agency evaluation of personal information
- Medical data, including diagnosis and past 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 the agency does have permission to share your information. This happens when the local agency, ODJFS or Ohio Department of Medicaid (ODM) checks the information you give. For example, the local agency may use your Social Security number when contacting other agencies or people to make sure that your information is correct and that you qualify for help. Here is how ODJFS and ODM may share your information:

- If somebody calls the agency asking for information about you, the agency must have either a signed release of information form from you or a signed authorized representative notice from you before any of your information can be shared.
- ODJFS or ODM may enter into data-sharing agreements with other agencies that will allow ODJFS or ODM to get or give Social Security, income, eligibility or medical insurance information (called third-party liability).
- If a court issues a subpoena for your case record, ODJFS or ODM will give your information to 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.
- In an emergency situation, if time does not allow ODJFS or ODM to receive your permission first, your information may be released. However, ODJFS and ODM must tell you if this happens.
- If you have checked a box on a combined program application requesting information about another program, your information may be shared with that program. This could include child support, the Women Infants and Children (WIC) program, the Bureau for Children with Medical Handicaps (BCMH), Child and Maternal Health, and Help Me Grow (HMG).

Sometimes agencies outside ODJFS or ODM will share information about you with ODJFS or ODM to help us make a decision about your benefits. This information can be used as proof of your eligibility, so you won't have to bring in documents yourself. These agencies include the U.S. Department of Health and Human Services, the Social Security Administration, the U.S. Department of the Treasury, the Ohio Department of Taxation, and the Ohio Department of Health.

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 gave us.
- Will not send you holiday greetings, general public announcements or political information (except voter registration materials).
- Will never share your information with companies or telemarketers.
- Will provide you with voter information and registration materials when you apply or reapply for benefits or when you report a change to your case.
- May send you information relating to your health and welfare, such as free medical exams, availability of surplus food and consumer protection information.

Rights and Responsibilities

Cash Programs

Ohio Works First provides cash assistance to eligible low-income families with children for up to 36 months. If you receive Ohio Works First or Refugee Cash Assistance, you must report to your county agency within 10 calendar days if:

- You move to another address.
- Someone moves in or out with you.
- Any household member's income (earned or unearned) goes up or down by more than $50.
- A child drops out of school.
- There is a change in the legal obligation to pay child support.
- A household member becomes pregnant or the pregnancy ends.
- Information related to an absent parent changes.
- A minor parent's living arrangement changes.
- A household member violates a condition of probation or parole.
- A household member becomes a fugitive felon.

Adults or minor heads of household may be required to participate in work activities. Work activities can include county-approved on-the-job training, community service and/or education. You should inform your caseworker of any employment barriers, such as difficulties with transportation, child care, or medical or physical limitations. Eligible adults or minor heads of household must sign a self-sufficiency contract. Failure to sign or comply with the terms of the contract will result in termination of benefits for the household. If you quit a job without just cause, you will be ineligible for benefits for six months.

You can choose to receive your monthly benefits through either the Ohio EPPICard™, which is a pre-paid debit MasterCard, or have them directly deposited into a checking or savings account. The EPPICard™ can be used at MasterCard member banks, ATMs and most retailers that accept MasterCard. It cannot be used at liquor stores, casinos, gaming establishments, or retail establishments that provide adult-oriented entertainment in which performers disrobe or perform in an unclothed state for your entertainment.

Child and Spousal Support and Ohio Works First

If you receive Ohio Works First benefits in addition to child or spousal support, all or part of your child or spousal support payments will be retained by the state to cover the cost of the Ohio Works First benefits. The state will not retain more than your Ohio Works First payment amount. If you receive support directly from an absent parent while you are participating in Ohio Works First, you must turn the support over to your local child support enforcement agency. This requirement is effective the first of the month following the date you are approved to receive Ohio Works First. Any support you received before then will be considered when determining how much Ohio Works First you may be eligible for during the first few months after you apply. If you began participating in Ohio Works First after October 1, 2009, and you are paid past-due child or spousal support that accumulated before the month you started to receive Ohio Works First, you will be allowed to keep that amount.

Food Assistance

If you are applying or reapplying for Food Assistance benefits, and your gross monthly income is more than the gross monthly income limit for your household size (as shown on your Food Assistance approval or change notice), you must report that fact to your county agency. You have 10 calendar days after the last day of the month in which the change first happens to do so. Reporting requirements are listed on the "Food Assistance Change Reporting" form (JFS 04196). Changes can be reported on this form, by telephone, electronically or in person by a member of the household.

To receive a deduction for the following expenses, you must report and provide verification:

- Your rent or mortgage payment

- Utility and/or shelter costs
- Medical expenses (if you are elderly or disabled)
- Dependent care expenses
- Legally obligated child or medical support paid to a non-household member.

Failure to report or verify any of the above will be seen as a statement by your household that you do not want a deduction for that expense. Applicants are responsible for providing verification to support their statements. If you have difficulty obtaining verification(s), contact your county agency, and they will help you as long as you have not refused to cooperate.

After you have received Food Assistance benefits for either five or 11 months, you will receive an Interim Report so you can provide updated information. If you do not complete, sign and return it by the deadline, your Food Assistance benefits will end. If you are an able-bodied adults ages 18 to 50 without dependents, you also must report when your work hours fall below 20 hours a week or 80 hours (on average) each month. Failure to report this could cause your benefits to end.

Medical Assistance

Ohio offers medical assistance through Medicaid, the Children's Health Insurance Program, the Medicare Premium Assistance Program and the Refugee Medical Assistance program. Each has unique requirements. In general, you must:

- Give your caseworker all the documents requested.
- Let your caseworker 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 medical assistance, ask for help from your caseworker. Also talk to your caseworker if you need help getting requested documents.

Food Assistance Work Requirements

The Food Assistance Program helps eligible, low-income individuals and families stretch their food budgets and buy healthy food. As a condition of eligibility, household members may be required to register for work. You are exempt from that requirement if you are:

- Younger than 16
- 60 or older
- A parent or other member of the assistance group who is responsible for the care of a dependent child under age 6 in or out of the home
- A parent or other member of the assistance group who is responsible for the care of an incapacitated person in or out of the home
- Applying for or receiving unemployment benefits and complying with all rules
- Physically or mentally unfit for employment, temporarily or permanently
- Applying for Supplemental Security Income and Food Assistance simultaneously at a local Social Security Administration office
- A regular participant in a drug addiction or alcoholic treatment or rehabilitation program, either as an out-patient or in-patient
- Enrolled at least half-time in any recognized school, training program or institution of higher education
- Complying with an Ohio Works First work requirement
- Employed and working at least 30 hours weekly or receiving weekly earnings equal to the federal minimum wage multiplied by 30 hours
- Self-employed and working at least 30 hours weekly or receiving weekly earnings equal to the federal minimum wage multiplied by 30 hours

If you receive or are applying for Food Assistance benefits and are required to register for work, you must do all of the following:

- Respond to all requests for information about your work status or availability for work
- Report to any employer referred by your county agency, unless the potential employment is unsuitable
- Accept suitable employment when it is referred by your county agency
- Maintain employment until it is no longer considered suitable, until you are terminated for reasons beyond your control, or until you become exempt from work registration
- If you are an able-bodied adult without dependents, participate in the Food Assistance Employment and Training Program and receive an appraisal of your work history, education level, skills and barriers

If you are required to register for work and receive an appraisal, and you fail or refuse, without good cause, to meet the requirements listed above, you will sanctioned. This means you will be denied benefits for a period of time or terminated from the program.

What is good cause?

Good cause includes circumstances beyond your control, such as illness, illness of a family member that requires your presence, family emergency, domestic violence, the unavailability of transportation, or the lack of adequate child care for children ages 6 to 12.

The following also are considered good cause for leaving a job:

- Discrimination by an employer based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by the U.S. Department of Agriculture
- Work demands or conditions that cause continued employment to be unreasonable, such as working without being paid on schedule
- If you accept a job or enroll in any recognized school, training program or institution of higher education on at least a half-time basis, which requires you to leave employment
- If another member of your household accepts a job or enrolls at least half time in any recognized school, training program or

institution of higher education in a location that requires the household to move
- If you are younger than 60, and your employer considers your resignation to be retirement
- If you leave a job in connection with seasonal patterns of employment, such as migrant farm labor or construction work
- If your job becomes unsuitable (see below)
- If you accept a job of more than 30 hours a week in which the weekly earnings are equivalent to the federal minimum wage multiplied by 30 hours, but – because of circumstances beyond your control – the job either does not materialize or results in unsuitable employment

If, within 60 days of applying for food assistance, you quit a job or reduce your work hours without good cause, you will be sanctioned for a specified time period.

If, while receiving food assistance, you quit a job or reduce your work hours without good cause, you will be sanctioned for a specified time.

If good cause is questionable, and you fail or refuse to provide verification of the questionable information, you will not be considered to have left employment for good cause.

What is unsuitable employment?

Employment is considered unsuitable if any of the following conditions exist:

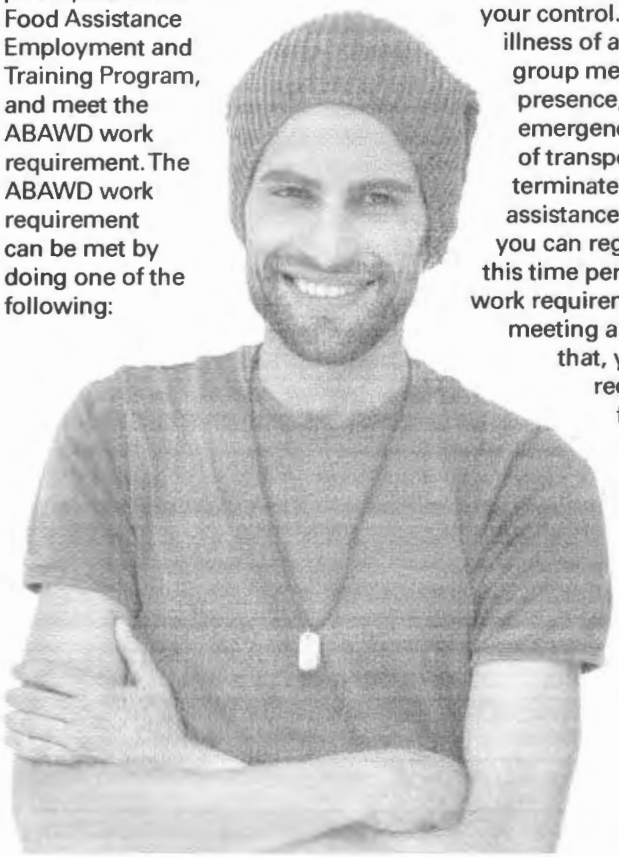
- The wage offered is less than the highest of:
  - o The applicable federal or state minimum wage or
  - o 80 percent of the federal minimum wage, if neither the federal nor the state minimum wage is applicable
- The employment offered is paid on a piece-rate basis, and the average hourly yield you can expect to earn is less than the applicable hourly wages
- Employment that requires you to join, resign from or refrain from joining any legitimate labor organization
- The work offered is at a site subject to a strike or lockout at the time of the offer, unless the strike has been enjoined under section 208 of the Labor-Management Relations Act of 1947 29 U.S.C. 141 (6/1947), or unless an injunction has been issued under section 10 of the Railway Labor Act of 1926, 45 U.S.C. 151 (10/1996)
- Any other criteria established by your county agency

Requirements for Able-Bodied Adults without Dependents

If you are required to register for work, you might also be considered an able-bodied adult without dependents (ABAWD). You are NOT an ABAWD if you are:

- Under age 18
- Age 50 or older
- A parent (natural, adoptive or step) of an assistance group member (eligible or ineligible) who is under age 18
- Live in an assistance group with someone under age 18 (eligible or ineligible)
- Medically certified to be physically or mentally unfit for employment, temporarily or permanently
- Pregnant

If you are an ABAWD, you are required to comply with the work registration requirements above, participate in the Food Assistance Employment and Training Program, and meet the ABAWD work requirement. The ABAWD work requirement can be met by doing one of the following:



- Work 20 hours per week (80 hours averaged monthly) in exchange for money, goods or services (in-kind work) or verified unpaid work averaged monthly. (Unpaid work is defined as doing or performing something for which no compensation is received and that benefits the community or a member of the community who you do not reside with.)
- Participate in and comply with the requirements of a work program – such as the Food Assistance Employment and Training Program or a workforce program through an OhioMeansJobs center) – for 20 or more hours per week.
- Any combination of working and participating in a work program for a total of 20 hours or more per week.
- Participate in and comply with a Work Experience Program as assigned by the county agency.

You are required to report to the county agency if your work hours fall below 20 hours a week or an average of 80 hours a month. If you do not meet the ABAWD work requirement, without good cause, during any three months in a 36-month period, you will be ineligible to receive Food Assistance benefits. Good cause is determined by your county agency and includes circumstances beyond your control. This includes illness, illness of another assistance group member requiring your presence, an assistance group emergency, or the unavailability of transportation. If you are terminated or denied food assistance for three of 36 months, you can regain eligibility during this time period by meeting the work requirement for 30 days or meeting an exemption. After that, you remain eligible to receive Food Assistance for as long as you continue to meet the work requirements or meet an exemption. If you do not meet the Food Assistance Employment and Training requirement, you will be sanctioned.

State Hearings

What if I don't agree with what happened on my case?

You can ask for a state hearing:

- If you don't agree with an action or decision regarding your case.
- If you think the county agency has not done something it should have.

What is a state hearing?

A state hearing is a meeting with you, your case worker and a hearing officer from the Ohio Department of Job and Family Services. At the hearing the county agency representative will explain what action the agency has taken or plans to take on your case. You will have a chance to explain why you don't agree.

You can bring other people with you to the hearing to speak on your behalf, such as friends, relatives, witnesses or an attorney. If you need free legal help, contact your local Legal Aid office. If you don't know the phone number, call 1-866-LAW-OHIO (1-866-529-6446), toll-free, or search the Legal Aid directory at **ohiolegalservices.org/programs**.

How do I ask for a state hearing?

If you want a state hearing, email your request to the Bureau of State Hearings at **BSH@jfs.ohio.gov**; call 1-866-635-3748, option 1, toll-free; or fax your request to 614-728-9574. You can also ask for a hearing by writing to:

State Hearings, Ohio Department of Job and Family Services

P.O. Box 182825,
Columbus, Ohio 43218

If you receive a notice from your county agency saying that it plans to reduce or stop your benefits, you can use the notice itself to request a state hearing. Directions for doing so can be found on the notice. Simply fill in the information requested and mail the form to the address provided. Check the mailing date on the notice. You must ask for a hearing within 90 days of that mailing date.

If your benefits are being reduced or stopped and you ask for a hearing within 15 days of the mailing date of the notice, your benefits will remain at the old amount until your hearing is decided. However, Food Assistance may not continue if it is the end of your Food Assistance certification period.

Is there another way to work out a problem?

Having an informal conference at the county agency is often a quicker way to solve a problem. At the conference, a county worker will look over your case and can correct any mistakes. You can call the agency to request a county conference. If the problem is not solved at the conference, you can still ask for a state hearing.

Before the Hearing

You may have someone else attend the hearing to present your case for you. This could be a lawyer, friend, relative or someone else with expertise about public assistance rights. If you are not going to be at the hearing, the person speaking for you must bring a written statement from you saying he or she is your representative.

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 1-866-LAW-OHIO (1-866-529-6446), toll-free, or search the Legal Aid directory at **ohiolegalservices.org/programs**. If you want notice of the hearing sent to your lawyer, you must give the Bureau of State Hearings your lawyer's name and address.

What happens at a state hearing?

After you ask for a state hearing, the Bureau of State Hearings will send you a notice providing the date, time and place of the hearing. The hearing could be held via telephone or in person at your county department of job and family services. If you can't go to the county agency, the hearing could be held somewhere else, possibly in your home. If you would prefer a telephone hearing, it is your responsibility to contact the Bureau of State Hearings to request a telephone hearing prior to the scheduled hearing date.

At the hearing, you, the county representative and a state hearing officer will meet to talk about your case. Your case worker will explain the agency's action. You can explain why you don't agree. 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.

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

Subpoena

You can ask the hearing authority 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 provide the name and the address of the person or document you want subpoenaed.

What if I missed the 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 within 10 days and explain why you did not come to the hearing. The hearing authority will decide whether you had a good reason. If you do not call within 10 days and show good cause, the hearing will be dismissed, and you will lose the hearing. The county agency can then go ahead 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.

When will I find out about the hearing officer's decision?

After the hearing, the hearing officer will review your case fairly and objectively. He or she will make a decision based on:

- The information given during the hearing
- Whether the rules were applied correctly

If your hearing is about Food Assistance benefits, you should get a written decision within 60 days of the date you asked for a hearing. In all other programs, you should get a decision within 90 days.

Compliance

If the hearing decision orders an increase in your Food Assistance benefits, you should get the increase 10 days from the decision date. If the decision orders a decrease in your Food Assistance benefits, you should get the new smaller amount the next month, whenever you normally receive your benefits. In all other programs, the agency must take action ordered by the decision within 15 days of the date the decision was issued, and always within 90 days of your hearing request. If you have not promptly received the benefits awarded by the hearing decision, contact the Bureau of State Hearings.

What if I don't agree with the decision?

If you don't 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 request an administrative appeal. If you don't agree with the administrative appeal decision, you can ask for a judicial review. A judicial review is an appeal to a court.

Civil Rights

Individuals eligible for, receiving services from, or benefiting from programs funded through the Ohio Department of Job and Family Services and Ohio Department of Medicaid 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.)

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 the federal Civil Rights law to be followed. If you do not want to provide this information, it will have no effect on your case.

Religious Agencies

County departments of job and family services have agreements with other agencies to provide services to families who may be receiving work support services through the Prevention, Retention and Contingency program, or to serve as work sites for parents receiving Ohio Works First. Some of the services or work sites may be at religious agencies, such as churches. If you do not want to go to a religious agency for services or to work, let your case worker know.

What is discrimination?

Discrimination is an action, policy or practice—whether purposeful or not—that results in unequal treatment of people. No one because of their protected class can be:

- Denied or delayed any service, aid or other benefit provided by an ODJFS program
- Subjected to segregation or disparate treatment in an ODJFS 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.

The key words are "because of." 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 unlawful or discriminatory.

Persons with Disabilities

All persons with disabilities are protected against unlawful discrimination by the Americans with Disabilities Act (ADA) and 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 agency has contracted with a private agency to help provide your benefits.

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 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.

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. With the exception of the use of eyeglasses or contact lenses, a determination about a person's disability should be made without regard to whether medical treatment or a device would permit the person to function ably.

A qualified individual with a disability is someone who is eligible for government benefits and services, such as Ohio Works First cash assistance or food assistance. ODJFS, your county agency, 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.

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 agency 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 equipment
- Restructuring training curricula, formats or training hours
- Providing special equipment (for example, 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, rest rooms, elevators and interior ramps.

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 agency know and let them know what works best for you.

If you are associated with a person with a disability, you also are protected. 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.

How to File 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. If you have questions about how to file a complaint, call the ODJFS Bureau of Civil Rights, toll-free, at 1-866-227-6353 or write to that office at the address shown below. If you need free legal help or advice, call 1-866-LAW-OHIO (1-866-529-6446), toll-free, or search the Legal Aid directory at ohiolegalservices.org programs. Complaints regarding incidents of alleged discrimination should be sent within 180 days of the date of the event to:

- The Ohio Department of Job and Family Services, Office of Employee and Business Services

  Bureau of Civil Rights
  30 E. Broad Street, 30th Floor
  Columbus, Ohio 43215-3414

  Telephone: (614) 644-2703 or
  Toll free 1-866-227-6353

  Fax: (614) 752-6381
  jfs.ohio.gov/civilrights/complaint.stm

ODJFS will review your complaint. If it is determined that discrimination occurred, the agency 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:

- Ohio Department of Medicaid, Office of Human Resources, Employee Relations

P.O. Box 182709
Columbus, Ohio 43218-2709

Telephone: (614) 995-9981
Fax: (202) 690-7442
Email: **ODM EmployeeRelations@medicaid.ohio.gov**

medicaid.ohio.gov/FOROHIOANS/AlreadyCovered/CivilRights.aspx

- Office for Civil Rights,
  U.S. Department of Health and Human Services

  200 Independence Ave. SW
  Washington, D.C. 20201

  1-800-368-1019

  hhs.gov/civil-rights/filing-a-complaint/complaint-process

- U.S. Department of Labor
  Civil Rights Center

  200 Constitution Ave.
  Room N-4123
  Washington, D.C. 20210

  (202) 693-6500
  Call 1-877-889-5627 if you have a hearing or speech problem.

  dol.gov/oasam/programs/crc/complaint.htm

Food Assistance Nondiscrimination Statement This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture USDA) also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (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. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027), found online at ascr.usda.gov and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- mail: U.S. Department of Agriculture
  Office of the Assistant Secretary for Civil Rights

  1400 Independence Avenue, SW
  Washington, D.C. 20250-9410

  fax: (202) 690-7442; or

  email: **program.intake@usda.gov**

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by state); found online at fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY). This institution is an equal opportunity provider.

Citizenship and Immigration Status

You must provide proof of citizenship and immigration status for every person in your household who wants to receive assistance.

Medicaid

Individuals who want to receive Medicaid benefits 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 benefits do not have to provide information about their citizenship or immigration status. Individuals who are applying for Alien Emergency Medical Assistance (AEMA) do not have to provide information about their citizenship or immigration status.

Food Assistance

All individuals in your household who want to receive Food Assistance must provide information about their citizenship or immigration status. If anyone in your household does not want to provide information about his or her citizenship or immigration status, that person can be designated as a non-applicant. This means that person will not be considered an applicant and will not be eligible for Food Assistance. Non-applicant household members are still required to answer questions that affect the eligibility of the applicant household members, such as information about income, resources, striker status and intentional program violations. The income and resources of all non-applicant household members must be considered when determining the household's eligibility and benefit level. Other members of your household will still be able to get Food Assistance if they are eligible for benefits.

Ohio Works First and Refugee Resettlement Program

Everyone in your family who wants to receive Ohio Works First or cash or medical assistance 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 get assistance if they are otherwise eligible. If you want to find out whether other family members are eligible for Ohio Works First or cash or medical benefits under the Refugee Resettlement Program, you will need to provide information about their citizenship or immigration status. You also will need to answer questions about your family's income and other questions asked by the county agency.

Medicaid Programs and Services

Ohio Medicaid and Medicaid-related programs provide access to health care services for individuals who qualify.

Conditions of Eligibility When Applying for Medicaid

To receive any kind of Medicaid, you must:

- Provide your Social Security number
- Live in Ohio
- Be a U.S. citizen or a qualified alien
- Give Ohio the right to get medical support and payments for your medical care from a third party
- Help Ohio establish the paternity of and obtain medical support for any Medicaid-eligible child
- Help Ohio identify and pursue 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 or Medicare)
- Meet the income, resource and other program requirements
- Select a managed care plan right away, if required.

Medicaid and Other Health Care Programs

In addition to the other conditions of eligibility, you will need to meet financial and resource requirements to receive Medicaid. The chart at right shows the verifications needed for each coverage type.

Medicaid Coverage Type	Verification Needed: Income	Resources	Other
SSI Medicaid: Medicaid coverage for individuals who receive Supplemental Security Income (SSI) benefits.			X
Adult Extension: Medicaid coverage for individuals ages 19-64.	X		X
Parents and Caretaker Relatives: Medicaid coverage for parents and caretaker relatives with children under 18.	X		X
Pregnant Women: Medicaid coverage for women throughout the pregnancy and 60 days postpartum.	X		X
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.	X		X
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 aliens.	X		X
Alien Emergency Medical Assistance (AEMA): Medicaid coverage for the treatment of emergency medical conditions for certain individuals who meet all Medicaid requirements other than the citizenship requirements.	X	X	X
Transitional Medical Assistance (TMA): Up to six months of Medicaid with quarterly reporting and potential for an additional six months of Medicaid coverage for families who would otherwise lose coverage because a family member got a new job or is earning more money.	X		X
Children in Care/Former Foster Children in Care: Medicaid coverage for children in the custody of a public children services agency, 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 birthdays, until they turn 26.			X
Continuous Eligibility for Children: Twelve months of continuous eligibility is available to every child up to age 19 who gets Medicaid.			X
Adults Age 19 and 20: Medicaid coverage for individuals ages 19 and 20. Family income may be used in the eligibility determination.	X		X
Non-MAGI Aged, Blind or Disabled (ABD): Medicaid coverage for people who are at least 65 years old and individuals of any age who are blind or disabled.	X	X	X
Medicare Premium Assistance Program (MPAP): Medicaid assistance programs that help pay Medicare costs. • Qualified Medicare Beneficiary (QMB): Pays Part A and B premiums, deductibles, co-pays and co-insurance. • 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.	X	X	X
Medicaid Buy-In for Workers with Disabilities (MBIWD): Medicaid coverage for working disabled individuals ages 16 to 64. If your income is above a certain amount, you may need to pay a premium to get MBIWD.	X	X	X
Residential State Supplement (RSS): A supplemental cash payment program for aged, blind or disabled people who meet a protective level of health care as determined by a health care provider. RSS helps to pay the costs of living in certain adult care facilities.	X	X	X
Long-Term Care or HCBS Waiver Services: Long-term care or waiver services are available for individuals who have special care needs, as determined by a health care provider and meet an intermediate or skilled level of care.	X	X	X
Program for All-Inclusive Care for the Elderly (PACE): A "total care" program run by both Medicare and Medicaid in Cuyahoga county.	X	X	X
Breast and Cervical Cancer Project (BCCP): Medicaid coverage for certain individuals who need treatment for breast or cervical cancer, 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.			X

Health Care Services Covered by Medicaid

Medicaid covers many services. For some services, you may need to pay a co-pay. There are no co-pay requirements for pregnant women and children. Some of the services you may receive are:

- Doctor Visits
- Dental Check-Ups and Cleaning
- Family Planning
- Pregnancy-Related Services
- Prescription Drugs
- Lab Testing and X-Rays
- Regular Eye Exams and Eyeglasses
- Hearing Services
- Prostate Tests (age 50 and older)
- Pap Smears/Pelvic Exams
- Home Health Services
- Hospital Care
- Flu Shots
- Long-Term Home and Community Care
- Care in a Nursing Home or an Intermediate Care Facility (ICF)
- Well-child checkups for newborns through age 20, including immunizations, through the Healthchek program.

Other Things You Need to Know About Medicaid

For information about any of these topics or if you have questions, please talk to your case worker or call the Ohio Medicaid Consumer Hotline at 1-800-324-8680 .

Help with Past-Due Medical Bills: If you incurred medical bills in the three months before you applied for Medicaid, Medicaid may be able to help pay for them. Contact your county department of job and family services for more information.

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

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

Estate recovery may be delayed or may not take place if you have:

- A surviving spouse
- A surviving child up to age 21
- 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

Even if none of these apply, your heir could argue that estate recovery would cause an undue hardship for him or her.

The Attorney General's office handles estate recovery. For more information, contact the Medicaid Estate Recovery Unit, 150 E. Gay St., 21st Floor, Columbus, Ohio 43215-3130.

Ohio's Partnership for Long-Term Care Insurance: Ohio long-term care insurance companies can now offer policies that qualify under the state's Long-Term Care Partnership Insurance Program. Partnership insurance offers a way for people to buy long-term care insurance, receive policy benefits and protect a matching amount of assets if they need to apply for Medicaid. Only you can decide if long-term care insurance is right for you. Visit **ltc4me.ohio.gov** for more information.

Medicare Part D Prescription Drug Benefit: If you have Medicare Part D coverage, Medicaid will not pay for your prescription drugs. However, you can apply for "Extra Help," a Medicare program that helps people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles and coinsurance. If you are found eligible for Extra Help, you won't have to pay a deductible, and your co-pay will be reduced. For more information, call 1-800-MEDICARE (1-800-633-4227) or visit **medicare.gov**

Home and Community-Based Waivers: Home and community-based waivers help Medicaid-eligible consumers remain at home instead of having to go to a nursing home, hospital or facility for people with developmental disabilities. Individuals enrolled in Medicaid waiver programs may receive nursing, daily living and skilled therapy services. For more information, visit **medicaid.ohio.gov/FOROHIOANS/Programs/HCBSWaivers.aspx**.

Food Assistance Penalty Warning

To make sure your household is eligible and receives the correct amount of Food Assistance benefits, federal, state and local officials will check the information you provide. The information will be checked by using the state income and eligibility verification system, the disqualified recipient subsystem, other computer matching systems, program reviews, and audits. Some information may also be sent to the U.S. Citizenship and Immigration Services (USCIS) to see if the information you gave is correct. Information about individuals not providing Social Security numbers will not be shared with USCIS.

The information you provided also may be checked by other federal aid programs and federally aided state programs, such as the National School Lunch Program, Ohio Works First and Medicaid. The information also may be verified through collateral contact(s) when discrepancies are found and the information may affect your eligibility and benefit amount. If you gave wrong information on purpose, you may be denied Food Assistance benefits, and legal action may be taken against you. If you are issued a benefit amount greater than you are entitled to, you also may have to pay back the amount that you should not have received.

If you were overpaid Food Assistance benefits, the information provided on your application, including all Social Security numbers, may be referred to other federal and state agencies, as well as private collection agencies, for overpayment claims collection action.

The providing of any requested information, including the Social Security number 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 Food Assistance benefits to your household. Failure to provide a Social Security number will result in the denial of Food Assistance benefits to each individual failing to provide a number. Any numbers provided will be used and disclosed in the same manner as numbers of eligible household members. Information collected on the application may be disclosed to law enforcement officials for the purpose of apprehending individuals fleeing to avoid the law.

Any member of your household who breaks any of the following rules on purpose will be subject to a penalty:

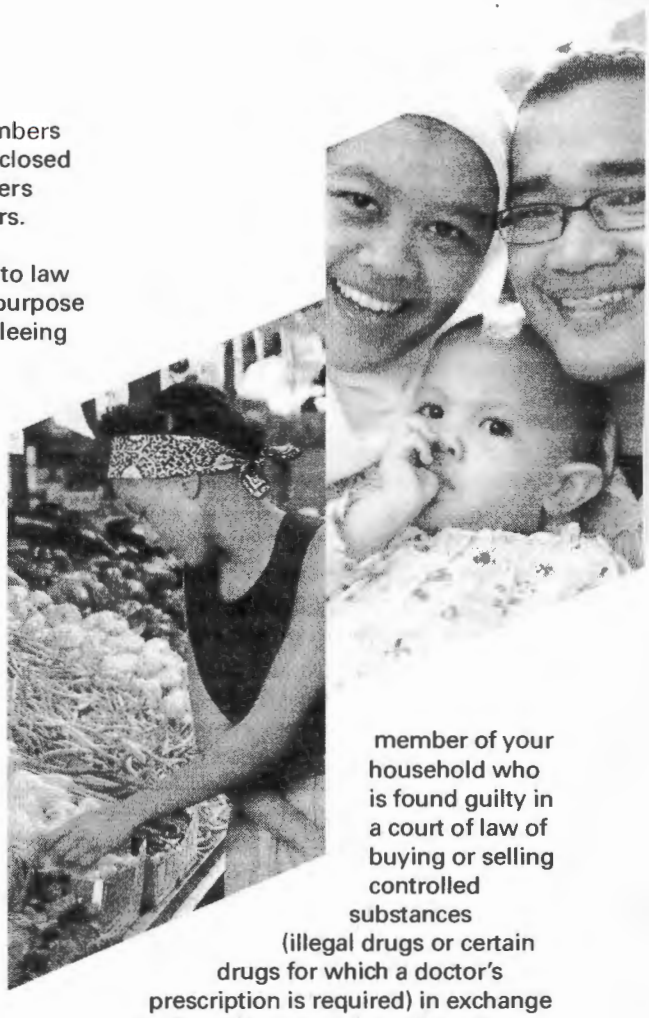
- Do not give false information, or hide information, to get or continue to get Food Assistance benefits.
- Do not trade or sell Food Assistance benefits.
- Do not alter any authorization document to get Food Assistance benefits you are not entitled to receive.
- Do not use someone else's Food Assistance benefits for your household.
- Do not use Food Assistance benefits to buy ineligible items, such as alcoholic drinks and tobacco.

The penalties include:

- 1st occurrence — Ineligible for Food Assistance for 12 months
- 2nd occurrence — Ineligible for Food Assistance for 24 months
- 3rd occurrence — Permanently ineligible for Food Assistance.

In addition, a court can ban an individual from the program for an additional 18 months. Depending on the amount of benefits involved, the individual can also be fined up to $250,000, sent to jail for up to 20 years, or both.

Any member of your household who is found guilty in a court of law of buying or selling firearms, ammunition or explosives in exchange for Food Assistance benefits will never be able to get Food Assistance benefits again. Any



member of your household who is found guilty in a court of law of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for Food Assistance benefits will not be able to get Food Assistance benefits for 24 months for the first offense and permanently for the second offense. Any member of your household who is convicted in a court of law of trafficking Food Assistance benefits for an aggregate amount of $500 or more will never be able to get Food Assistance benefits again.

Any member of your household found to have made a false statement or knowingly provided false information with respect to identity and residence in order to receive more than one benefit at the same time will not be able to get Food Assistance benefits for 10 years.

We may check Ohio records and records from other states to see if anyone in your household has broken Food Assistance rules before and should not be getting Food Assistance benefits because he/she has not finished serving a disqualification period for breaking the rules.

Social Security Numbers

You must provide the county agency with a Social Security number, or apply for a number, for each person applying to receive assistance. You may not need to provide this information in all situations. The collection of this information, including the number 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 5101:1-1-03, 5160:1-1-58 and 5101:1-3-09 of the Ohio Administrative Code.

The number will be used to check information that you provided against information held by other federal, state and local governments; computer matching systems; and program reviews or audits to make sure you are eligible for public assistance programs. To the extent permitted by federal law, it also will be used to assist with determining eligibility for any other state or federal assistance program that provides cash or in-kind assistance or services directly to individuals based on need or for the purpose of protecting children. This information will also be used to monitor compliance with program regulations and for program management.

The Social Security number will be used when contacting appropriate persons or agencies to determine your eligibility and to verify information you have given for any public assistance program. These programs include, but are not limited to, Ohio Works First, Medicaid, Food Assistance, the National School Lunch Program, public children services agency programs, and Prevention Retention and Contingency programs. The information verified can include income, past or present employment, financial resources, unemployment compensation, disability benefits, or other similar benefits and programs. Such information may affect your household eligibility and level of benefits. If you provide false information, legal action may be taken against you.

Individuals who want to receive Medicaid must provide a Social Security number or apply for one. Individuals in the same household who do not want to receive Medicaid do not have to provide a number. If you do not want to receive Medicaid but you provide your Social Security number voluntarily, your number will be used to verify income. It also may be used to contact other health insurers to explore whether other health coverage is available to pay all or part of your medical bills.

Everyone in your household who wants to receive Food Assistance must provide their Social Security numbers. The numbers will be used to check the identity of household members, prevent duplicate participation and make mass changes easier. If you apply for or are receiving Food Assistance benefits, and through a match with your Social Security number it is found that you have an outstanding felony warrant or that you are in violation of probation or parole, your current address may be released to appropriate law enforcement agencies.

If anyone in your household does not want to provide information about his or her number, that person can be designated a non-applicant. This means that person will not be considered an applicant and will not be eligible for Food Assistance benefits. Non-applicant household members are still required to answer questions that affect the eligibility of the applicant household members, such as information about income, resources, striker status and intentional program violations. The income and resources of all non-applicant household members must be considered when determining the household's eligibility and benefit level.

Each person in your family who wants to receive Ohio Works First benefits must provide their Social Security numbers. Your number may also be used by public children services agencies to provide services to your family and to verify benefits or services. If you apply for or are receiving Ohio Works First or Prevention, Retention and Contingency services, and through a match with your Social Security number it is found that you have an outstanding felony warrant or that you are in violation of probation or parole, your current address may be released to appropriate law enforcement agencies. Your Social Security number also may be used for purposes of investigations, prosecutions, and criminal or civil proceedings that are within the scope of law enforcement agencies' official duties.

Certain members of your family may be ineligible for benefits because of their immigration status. If that happens, other family members may still be able to receive benefits.

For cash and medical assistance through the Refugee Resettlement Program, you do not have to provide a Social Security number. The county agency may request that you provide a Social Security number, but the agency must tell you how it will use the number. Providing the number is voluntary.

Fraud

You may receive help you are not entitled to:

- If you don't tell the truth about yourself.
- If you don't tell your county agency about changes that affect your case. Report your changes within 10 calendar days.

If you get help you should not have gotten:

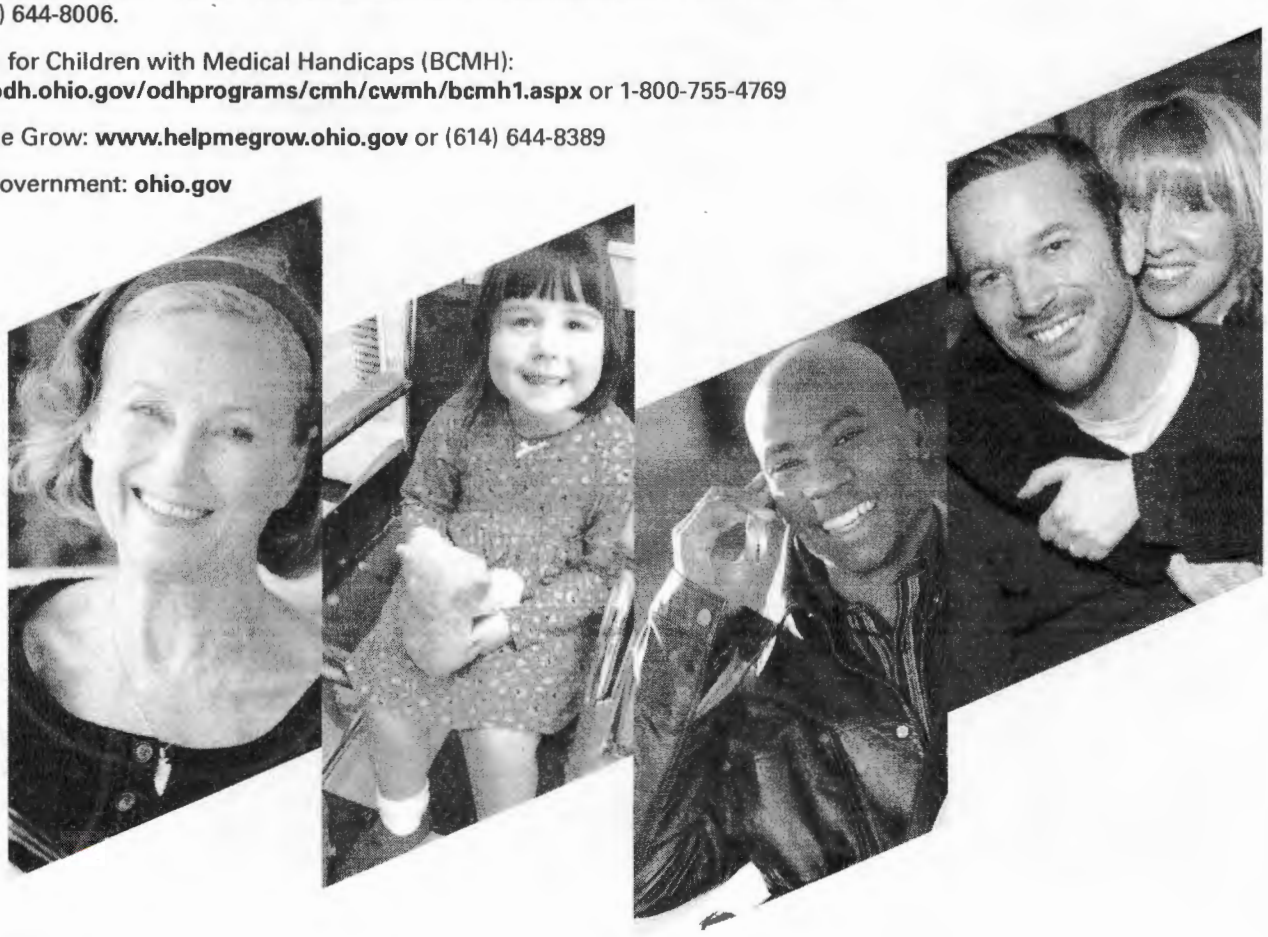
- You may be ordered to pay it back.
- You may be charged with fraud.
- You may be fined or sent to prison.
- You may be stopped from getting help in the future.

Quality Control

Cases are chosen at random throughout the state to make sure that people are eligible for the assistance they receive and that they are receiving the correct amount. You must cooperate if your case is reviewed. If you refuse to cooperate with a review, your benefits may be terminated.

Helpful Resources

- ODJFS programs: **jfs.ohio.gov** or call 1-866-ODJFS4U (1-866-635-3748)
- To apply online or to report a change for Ohio Works First, Food Assistance and/or Medicaid: **odjfsbenefits.ohio.gov**
- Medicaid Consumer Hotline: 1-800-324-8680
- To apply online for Medicaid: **benefits.ohio.gov**
- County agencies: **jfs.ohio.gov/county**
- Ohio Benefit Bank: **ohiobenefits.org**
- Social Security Administration: **ssa.gov** or 1-800-772-1213
- Medicare: **medicare.gov** or 1-800-MEDICARE
- Unemployment Compensation: **unemployment.ohio.gov** or 1-877-644-6562 (OHIOJOB)
- Ohio's Best Rx: **ohiobestrx.org** or 1-866-923-7879
- Register to Vote: **MyOhioVote.com**
- Women, Infants and Children (WIC): **odh.ohio.gov/odhprograms/ns/wicn/wic1.aspx** or (614) 644-8006.
- Bureau for Children with Medical Handicaps (BCMH): **www.odh.ohio.gov/odhprograms/cmh/cwmh/bcmh1.aspx** or 1-800-755-4769
- Help Me Grow: **www.helpmegrow.ohio.gov** or (614) 644-8389
- Ohio Government: **ohio.gov**



Ohio | Department of Job and Family Services

John R. Kasich, Governor State of Ohio

Cynthia C. Dungey, Director
Ohio Department of Job and Family Services

Ohio Department of Medicaid

John R. Kasich, Governor State of Ohio

Barbara Sears, Director
Ohio Department of Medicaid

JFS 07501 (Rev. 4/2018)

Ohio Department of Job and Family Services

APPLICATION / REAPPLICATION VERIFICATION REQUEST CHECKLIST

Assistance Group Name	Application Date	Case Number	Interview Date/2nd Notice Date

Certain eligibility factors must be verified before the county department of job and family services can determine your eligibility for _____. Checked below are the documents you still need to provide:

Verifications still needed:	Time period:
☐ Birth certificate/Birth verification/Citizenship verification (Birth certificate, passport or similar document)	
☐ Health insurance card (copy of front and back)	
☐ Income verification (pay stubs, tax records, award letters, child support)	
☐ Marriage certificate	
☐ Medical form completed by doctor	
☐ Pregnancy verification (including number of fetuses)	
☐ Proof of any child/dependent care costs	
☐ Proof of any child support paid for children not living with you	
☐ Proof of any medical costs for people with disabilities or for people who are age 60 and over (including prescriptions)	
☐ Proof of identity (driver's license, state ID, passport)	
☐ Proof of current value of stocks/bonds, certificates of deposit, life insurance, trusts, annuities	
☐ Recent statements for any bank accounts (checking, credit union, savings)	
☐ Rent/Mortgage receipt	
☐ Rights and Responsibilities	
☐ School attendance verification	
☐ Social security cards (or proof you have applied) for:	
☐ Title to motor vehicles	
☐ Unemployment compensation/Worker's compensation verification	
☐ Utility receipts or copy of bills	
☐ Other, specify:	

If you are unable to get any of the above verifications, we may be able to help you. Please contact me immediately if you cannot get the verifications.

We must have the verifications listed above by _____. If we do not have the required information or verifications by this date, your application may be denied or your current benefits stopped.

Return all verifications to:

Address		
City	**State**	**Zip Code**
E-Mail	**Fax Number**	

Name of Caseworker	Date	District	Telephone Number

Your Civil Rights:

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Ohio Department of Job and Family Services

FOOD ASSISTANCE CHANGE REPORTING

To be Completed by Caseworker	
Name	Assistance Group Number
Return Form to County Address:	Date Received
Caseworker Phone	Caseworker Fax

If you are receiving food assistance you must report if:

If you or a member of your assistance group is subject to the work requirement for able-bodied adults without dependents you must report if your work hours fall below 20 hours weekly or 80 hours averaged monthly.

Your gross monthly income goes above the allowable gross monthly income limit for your assistance group size. See the chart below:

2018 Food Assistance Gross Monthly Income Guideline Reference Table (effective October 2017)										
130% FPG	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	$1307	**$1760**	**$2213**	**$2665**	**$3118**	**$3571**	**$4024**	**$4477**	**$4930**	**$5383**

Gross monthly income means the amount of all income before taxes (i.e. wages, child support, Social Security, Supplemental Security Income (SSI), unemployment compensation, annuities, pensions, retirement, veterans' or disability benefits) received by your assistance group prior to any taxes or deductions.

You are not required to report any other changes for food assistance until you receive your interim report or at recertification. This does not change your reporting requirements for other programs. If your assistance group contains an elderly or disabled member and you are already over the gross monthly income limit listed above you only need to report if your income changes.

Reminder: If your address changes notify your caseworker immediately. If your caseworker does not have the correct address for you, you will not receive required information to continue receiving your benefits.

CHECK YOUR TOTAL GROSS MONTHLY INCOME AT THE END OF EVERY MONTH

	Earned Income (i.e. job, self employment)		Unearned Income (i.e. SSI, social security, child support)
1st week	$	1st week	$
2nd week	$	2nd week	$
3rd week	$	3rd week	$
4th week	$	4th week	$
5th week	$	5th week	$
Total:	$	Total:	$

Add the total amount of all earned and unearned income

Earned total: _____

Unearned total: + _____

Total gross monthly income: = _____

CHANGES IN ABAWD EMPLOYMENT STATUS AND GROSS MONTHLY INCOME MUST BE REPORTED ON PAGE TWO OF THIS FORM.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR CASEWORKER

Return this Page to your caseworker to report your changes.

Does your household's income exceed the gross monthly income limit? ☐ Yes ☐ No

What is your current gross monthly income? $

ABAWDS: Did your weekly hours of employment drop below 20 per week ☐ Yes ☐ No

Will the change(s) you reported continue beyond the report month? ☐ Yes ☐ No

If no, explain in this space:

Reminder:
If you have verification of your new income amount please send copies of pay stubs, award letter(s), a letter from your employer, court support order, etc. to your caseworker.

To receive a deduction for the following expenses you must report and provide verification to your caseworker of: rent or mortgage payment, utility and/or other shelter costs, medical expenses, and legally-obligated child support paid to a non-household member. Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the expense.

➧ **Please read the penalty warning below before signing, dating, and returning this form.**

PENALTY WARNING

The information provided on this form will be subject to verification by federal, state, and local officials. If any information is found inaccurate, you may be denied food assistance benefits, and/or be subject to criminal prosecution for knowingly providing false information. If your assistance group receives food assistance benefits, it must follow the rules listed below. Any member of your assistance group who breaks any of these rules on purpose can be barred from the Food Assistance Program for 12 months for the first violation, 24 months for the second violation, and permanently for the third violation; fined up to $250,000, imprisoned up to 20 years, or both; and subject to prosecution under other applicable federal laws. A court can also bar you from the Food Assistance Program for an additional 18 months.

Any individual found guilty of food assistance trafficking by a federal, state, or local court shall be barred for 24 months for the first offense and permanently for a second offense involving the sale of a controlled substance for food assistance benefits, and permanently barred for the first offense involving the sale of firearms, ammunition, or explosives for food assistance benefits or trafficking of food assistance benefits of $500 or more. An individual found to have made a false statement or knowingly provided false information with respect to identity and residence in order to receive more than one benefit at the same time can be barred from the Food Assistance Program for 10 years.

- **Do not give false information or withhold information in order to continue receiving food assistance benefits.**
- **Do not give, trade, or sell food assistance benefits, authorization cards, or any authorization document.**
- **Do not alter authorization cards or any other authorization document to get food assistance benefits you are not entitled to receive.**
- **Do not use food assistance benefits to buy unauthorized items, such as alcoholic beverages, tobacco, paper products, pet foods, soap and other cleaning goods.**
- **Do not use someone else's food assistance benefits for your assistance group.**

YOUR SIGNATURE:
I understand the penalty for withholding information. I also understand I would have to repay any food assistance benefits I received because I did not fully report required changes to my caseworker. If asked, I agree to prove changes I report. My answers on this form are correct and complete to the best of my knowledge.

Your Signature	Date	Telephone Number

Your Civil Rights:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

This page is left intentionally blank.

Ohio Department of Job and 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).

Benefits of Cooperating

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

- Finding the absent parent.
- Legally establishing your child's paternity.
- Establishing a child support order for your child.
- Enforcing the child support order.
- The possibility that support payments might be higher than your public assistance grant.
- The possibility that your child(ren) may obtain rights to future Social Security, Veterans', or other benefits.

What is meant by cooperation?

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

- 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;
- Come to the CSEA or court, if necessary, to give information about the parent of your child.

Child support cooperation is a provision in your self-sufficiency contract. 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:

- For a first failure or refusal, we shall terminate your OWF for one month;
- For a second failure or refusal, we shall terminate your OWF for three months;
- For a third or subsequent failure we shall terminate your OWF for six months.

Do you have a good reason for not cooperating?

If cooperating with the CSEA would not be in the best interests of the child or would make it more difficult for you or the child 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 of the cooperation requirement when:

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

Written Documentation

It is your responsibility to provide the CSEA written documentation within 45 days of requesting a good cause waiver so the CSEA can determine whether you have good cause for refusing to cooperate.

Written documentation is acceptable from any one of the following:

- A court, police, or other governmental entity, shelter, legal, religious, medical, or other professional from whom you have sought assistance in dealing with domestic violence, CDJFS, or other person with knowledge of the domestic violence, if your reason for claiming good cause is because of domestic violence.
- A court, attorney, child protective services agency, or social services agency that indicates that legal adoption proceedings for the child are pending before a court, or adoption of the child is under active consideration, and cooperation would not be in the best interests of the child.
- A medical professional, law enforcement agency, or vital records agency that verifies that the child was conceived as a result of incest or rape and cooperation would not be in the best interests of the child.

If your reason for claiming good cause is that you or the child is being subjected to domestic violence and you cannot obtain written documentation, the CSEA can accept a written statement from you.

****

Please check the following that apply to you.

☐ 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.

☐ I want to ask the CSEA for a good cause waiver.

Printed Full Name of Individual Requesting Good Cause Waiver	Case/cat/seq
Signature of Applicant/Participant	Date
Signature of Worker	Date

Do you want us to send all letters and correspondence to you about domestic violence to a different address or call you at a different phone number to protect your safety?

☐ **YES** ☐ **NO**

If you do, please put the address you want us to send information about your request for domestic violence waivers below.

Alternate address
Street address
City/State/Zip code
Alternate phone number *(include area code)*

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 (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."

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

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, government check, paycheck, or government document (other than a notice of voter registration mailed by a board of elections) that shows the voter's 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.

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

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 (if necessary)	8. County (where you live)

9. Birthdate (MM/DD/YYYY) (required)	10. Ohio Driver's License number OR Last Four Digits of Social Security number (one form of ID required to be listed or provided)	11. Phone Number (voluntary)

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

Previous City or Post Office	Previous County	Previous 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** (MM/DD/YYYY) _____

FOR BOARD USE ONLY
SEC4010 (rev. 4/15)

City, Village, Twp.

Ward

Precinct

School Dist.

Cong. Dist.

Senate Dist.

House Dist.

TO ENSURE YOUR INFORMATION IS RECEIVED, PLEASE DO THE FOLLOWING:

1. Print this form.
2. Make sure all required fields are complete.
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 (877-767-6446).

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 (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 voter registration mailed 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 (877) 767-6446.

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

13183 State Route 13, Millfield, Ohio 45761-9901
(740) 797-2523 1-800-762-3775
http://jfs.athensoh.org
COMMISSIONERS: Lenny Eliason, Charlie Adkins, Chris Chmiel
EXECUTIVE DIRECTOR: Scott Zielinski
An Equal Opportunity Employer Service Provider

A DESIGNATED VOTER REGISTRATION AGENCY
VOTER REGISTRATION
DECLINATION NOTICE – NOTICE OF RIGHTS

(National Voter Registration Act of 1993; Section 3503.10 of the Ohio Revised Code)

You are being offered a voter registration application. As a state-designated voter registration agency, you will be offered a voter registration application with ALL applications, reapplications, name changes and changes of address.

Do you want to register to vote or update your current voter registration? Yes ☐ No ☐

IF YOU **DO NOT** MARK EITHER YES OR NO, 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 or the extent of the service that you will be provided by this agency.

If you would like help in 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.

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, you may file a complaint with:

Athens County Prosecuting Attorney
Athens County Courthouse
Athens, OH 45701
(740) 592-3208
www.athenscountyprosecutor.org

OR

Ohio Secretary of State
180 East Broad Street
Columbus, OH 43215
(614) 466-2655 or
Toll-free: 1-877-767-6446
www.sos.state.oh.us

If the board of elections accepts your voter registration application, the board must register you to vote not later than 20 business days after receiving your application and promptly mail a notice to your voting residence address confirming that you are registered to vote, identifying your voting precinct and the location of your precinct polling place, and stating the identification requirements for voting. If you do not receive a notice that your registration was accepted or rejected, contact your county board of elections before Election Day to determine if the board received your application. **Athens County Board of Elections: 740-592-3201**

Today's Date:	Expect notification by:

Form No. 11-A Prescribed by the Secretary of State (08-17)

Absentee Ballot Application

print clearly

R.C. 3509.03

Voter Name
Required

1

First _____ Middle _____

Last _____ Suffix _____

Date of Birth
Required

2

Date of Birth *(do not write today's date here)* _____ MM/DD/YYYY

Address at Which you are Registered to Vote
Required

3

Street Address *(no P.O. boxes)* _____ County _____

City/Village _____ ZIP _____

Mailing Address
Required *only if you wish to have your ballot mailed to a different address than the address at which you're registered to vote.*

4

Street Address *(or P.O. box)* _____

City/Village _____

State _____ ZIP _____

Identification
Required

*You must provide **ONE** of the following.*

5

☐ Your Ohio driver's license number *(2 letters followed by 6 numbers)* _____ **OR**

☐ Last four digits of your Social Security number _____ **OR**

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

Election
Required

You must complete a separate application for each election.

6

Date of Election *(do not write today's date here)* _____ MM/DD/YYYY

☐ **General Election** ☐ **Special Election**

☐ **Primary Election** For a PARTISAN primary election only, you must choose the type of ballot:

☐ Political party ballot Name of Political Party _____ ☐ Issues only ballot

Affirmation
Required

7

- I wish to have an absentee ballot mailed to me at the address listed above.
- I understand this request must be received by my board of elections no later than noon on the Saturday before Election Day if by mail or by 2 p.m. the day before the election if in person.
- I understand that if an absentee ballot is mailed to me and I change my mind and go to my polling place to vote on Election Day, I will be required to vote a provisional ballot that cannot be counted until at least 11 days after Election Day.
- I understand that, if I do not provide the required information, my application cannot be processed.
- **I hereby declare, under penalty of election falsification, that I am a qualified elector and the statements above are true.**

Signature X _____

Today's Date _____ MM/DD/YYYY

To assist the board of election in contacting you in a timely manner if your application is incomplete, please provide the following information.

Telephone Number _____ E-mail Address _____

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