Ohio Department of Medicaid

APPLICATION FOR HELP WITH MEDICARE EXPENSES

Medicaid can assist you in paying costs connected to *Medicare*. All or part of your Medicare expenses can be paid by the Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), Qualified Individuals (QI-1), or Qualified Disabled Working Individuals (QDWI) categories of Medicaid. Please complete this application and submit it to your local County Department of Job and Family Services (CDJFS) to apply for this type of assistance.

- A face-to-face interview is not required.
- You must supply proof of U.S. citizenship or alien status, income, and resources.
- This is not an application for cash or food assistance.
- If you would like to apply for any other kind of help, or have your eligibility for other forms of Medicaid evaluated, please inform your local ODM.

If you have questions or need assistance completing this application, please call your local CDJFS or call the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

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 here today?

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

If you do not check either box, you will be considered to have decided not to register to vote at this time.

Name of Applicant *(First, MI, Last)*		Phone Number	Date of Birth
Street Address			Social Security Number
City	State **OH**	Zip	Social Security CLAIM Number

Place of Birth	Race/ethnicity *(optional)*	☐ American Indian/Alaskan Native
Are you a U.S. citizen? ☐ Yes ☐ No If not, you will be asked to show an alien registration card and INS forms.	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

Is the Medicare Part B premium taken out of your Social Security check? ☐ Yes ☐ No If yes, when did the withdrawal begin? __________________	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed If you are married, does your spouse receive Medicare? ☐ Yes ☐ No Does your spouse want help with Medicare expenses? ☐ Yes ☐ No If yes, spouse's name ______________________ Date of Birth _______________ Social Security Number _________________________

Health Coverage. List any health insurance or health coverage you have:

Insurance Company/Plan	Policy Number	Monthly Cost	What Does the Policy Cover?
		$	
		$	
		$	

Income. List all of your income below, including but not limited to income from annuities, Social Security, SSI, VA benefits, spousal support, employment, retirement, or money regularly received from friends and family. Include all of your spouse's income.

Employer/Source of Income	Gross Amount	How Often Is Income Received?
	$	
	$	
	$	
	$	

Real Estate. Do you own part or all of any real estate other than your home? This includes but is not limited to other houses, vacant land, farm land, or business property. ☐ Yes ☐ No
If yes, please tell us about the property:

Street Address, City, State, Zip	Value $
Street Address, City, State, Zip	Value $
Street Address, City, State, Zip	Value $

Other Resources. List all of your current resources or assets (except real estate) owned by you or your spouse, including (where appropriate) account numbers and current balances or values. The following are examples of resources:

Savings accounts, Stocks/bonds, Vehicles, Christmas clubs, Land contracts
Checking accounts, Tax shelter accounts, 401(k)s or IRAs, Money Market funds, Trusts
Promissory notes, Certificates of deposit, Keough plans, Life insurance, Burial accounts

Type of Resource	Account/Policy #	Name of Bank, Insurance Co., Etc.	Value
			$
			$
			$
			$
			$

Would you like help with Medicare expenses for the past three months? ☐ Yes ☐ No
If yes, please provide verification of your income for each of the past three months.
(Note: This help is not available for certain categories of assistance.)

BY SIGNING THIS APPLICATION, I AGREE to give documentation and verification of information on this application. I understand I may be asked to give consent to the CDJFS to make whatever contacts are necessary to determine my eligibility.

I state under penalty of perjury that I have disclosed all annuities and other similar financial devices in which I or my spouse have any interest.

I authorize any person who furnishes health care or medical supplies to give the Ohio Department of Medicaid 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 Health and the Ohio Department of Medicaid to exchange any information I have provided on this form, to enable the departments to determine my eligibility.

I understand that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

By my signature below, I affirm that to the best of my knowledge and belief the answers on this application are complete and correct. I understand the law provides a penalty of fines or imprisonment (or both) for anyone convicted of accepting assistance he or she is not eligible to receive. **I state under penalty of perjury that all of the information on this application is true and complete to the best of my knowledge.**

Person Applying *(Please Print Name)*	Signature	Date
Authorized Representative or Person Who Completed Form	Signature	Date

If you have not been provided with a copy of forms JFS 07236 " Your Rights and Responsibilities as a Consumer of Medicaid Health Coverage" or JFS 07400 "Ohio Medicaid Estate Recovery," please ask for these informational forms from your local CDJFS or from the Consumer Hotline **at 1-800-324-8680 or TDD 1-800-292-3572, or visit http://www.odjfs.state.oh.us/forms/inter.asp.**