SNAP, CASH, MEDICAL, AND/OR ECE ASSISTANCE APPLICATION

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

Step 1: Check the box for each program the applicant wants to apply for

You can apply for any and all of the programs listed below. If you do not check any boxes, we will only review your eligibility for SNAP.

☐ **SNAP**

☐ **Cash Assistance**- For families with a minor child(ren) or women who are pregnant

☐ **Refugee Cash Assistance** (RCA)- For refugees within 4 months of arrival

☐ **Medical Assistance**

☒ **OPP**- Preschool for ages 3 to kindergarten eligible

☐ **PFCC/CCVP**- Child Care for families working, in school/training

Step 2: Tell us about the applicant

If you are an Authorized Representative, enter information about the person you are applying for.

First Name	Middle Initial	Last Name

Do you need any of the following services?

☐ Large Print Notices ☐ Sign Language Interpreter

☐ Translator ☐ Other _____

What is your preferred language?

Spoken: _____

Written: _____

Have you, or anyone living with you, ever received SNAP, Cash, Medical, or ECE Assistance?

☐ **No**

☐ **Yes** - If yes, who: _____

Location (City/County/State): _____

Step 3: Tell us how to reach the applicant

If you are an Authorized Representative, enter information about the person you are applying for.

Home Address ☐ Check here if you do not have a permanent address - please provide a mailing address

City	State	Zip Code

Phone *(Cell)*	Phone *(Home)*	Email Address

Address where you get mail (if different)

City	County	State	Zip Code

Reminder: Did you tell us which program(s) the applicant is applying for? Make sure to check the appropriate box(es) in Step 1.

Step 4: Tell us if you are an Authorized Representative

An Authorized Representative is someone who helps the applicant with the application process and can act on the applicant's behalf. ***If you are filling out this form as an Authorized Representative, please give us the following information about yourself. The applicant may be asked to give an authorization document.*** *You will not be listed as an Authorized Representative until the document is provided.*

First Name	Middle Initial	Last Name

Street Address

City	State	Zip Code

Phone *(Cell)*	Phone *(Home)*

Email Address

Do you need any of the following services?

☐ Large Print Notices ☐ Sign Language Interpreter

☐ Translator ☐ Other _____

What is your preferred language?

Spoken: _____

Written: _____

Step 5. For SNAP Applicants and SNAP Authorized Representatives ONLY

By signing below, you agree that you have **reviewed and agree to the terms in Step 14** and you certify, under penalty of perjury, the truth of the information contained in this application, including information provided below concerning citizenship and qualified non-citizen status of the members applying for benefits.

While you may submit your application with only the information provided above, your application may be processed more quickly if you continue to provide responses to the questions below.

Signature of Applicant OR Authorized Representative	**Date**

Print Name of Applicant OR Authorized Representative	**Date**

Step 6: Answer the following ONLY if applying for SNAP benefits

How many people live with you and buy, fix, and eat meals with you?_____

This number is considered your **"household"**, keep this in mind when answering the next two questions.

Note: *Your responses will help us decide if you can get SNAP more quickly. If someone else you live with is already receiving SNAP benefits, you may still be eligible for SNAP benefits.*

Is your household's total gross income before taxes for the current month less than $150? ☐ **Yes** ☐ **No**

Is your household's total net income for the current month zero after taxes and paying for such things as housing costs, child/dependent care costs, or child support payments?	☐ Yes ☐ No
Are your total resources in cash, checking, and savings accounts $100 or less?	☐ Yes ☐ No
Are your monthly rent or mortgage and utilities (such as gas, electric, water, and phone) more than your total monthly gross income before taxes?	☐ Yes ☐ No
Are you a migrant or seasonal farm worker?	☐ Yes ☐ No

Step 7: Tell us the applicant's information

You must list everyone who lives with you even if they are not applying. Please be sure to list your name first. If you need more space, write your answers on an extra piece of paper and attach it to this form. **Please use the following to assist with completing the section below:**

- **Social Security Number (SSN):** If you, or anyone else in your household, is NOT a U.S. citizen, or a Qualified Non-Citizen, you do not have to give us an SSN. If there are other reasons that you, or someone in your household does not have an SSN, please write that below (ex: pending SSA application).
- **U.S. Citizen:** You only have to tell us if someone is a U.S. citizen if they are applying for SNAP, Cash, Medical, or ECE Assistance.
- **Race/Ethnicity:** Title VI of the Civil Rights Act of 1964 allows us to ask for racial/ethnic (Hispanic or Latino) information. Providing this information is voluntary and is used for informational purposes only. If you do not want to give us this information, it will have no effect on your case.

Name	Relationship to You (spouse, friend, etc.)	SSN (See instructions above)	Date of Birth	Sex	U.S. Citizen	Hispanic or Latino	Race
	Self			☐M ☐F	☐Y ☐N	☐Y ☐N	
				☐M ☐F	☐Y ☐N	☐Y ☐N	
				☐M ☐F	☐Y ☐N	☐Y ☐N	
				☐M ☐F	☐Y ☐N	☐Y ☐N	
				☐M ☐F	☐Y ☐N	☐Y ☐N	

Are you married? ☐ **No** ☐ **Yes** - If yes, spouse's name: _____

Are you, or anyone you are applying for, pregnant?

☐ **No** ☐ **Yes** - If yes, who and when is the due date? _____

Do you, or anyone you are applying for need in-home care or nursing home services?

☐ **No** ☐ **Yes** - If yes, who? _____

Are you or anyone in your household caring for a disabled person in or outside of the home?

☐ **No** ☐ **Yes** - If yes, who? _____

Are you or anyone in your household in the military?

☐ **No** ☐ **Yes** - If yes, please select all that apply: ☐ **Active Duty** ☐ **National Guard/Reserves**

Have you ever been found guilty of Child Care fraud? ☐ **No** ☐ **Yes**

Step 8: Household members 60 years of age or older

Is anyone 60 years of age or older?

☐ **No** - If no, please skip to Step 9. ☐ **Yes** - If yes, answer the following questions in Step 8.

Is this person(s) receiving disability benefits?

☐ **No** ☐ **Yes** - If yes, from what source? _____

Is this person(s) unable to prepare meals due to a disability?	**No**	**Yes**
If you answered "Yes" to all three questions in Step 8, does this person(s) want to receive SNAP separately from the other people you live with?	**No**	**Yes**

Step 9: Tell us about the household's finances

Have you or the people in your household received, or expect to receive, income* this month?

☐ **No** ☐ **Yes** - If yes, please complete the table below.

***Income** refers to all the money that you and the people in your home receive. This includes earnings from employment or self-employment, child or spousal support, disability benefits, retirement benefits, Workers' Compensation, Unemployment Compensation, Social Security, SSI, Veterans' Benefits, Ohio Works First (OWF), gifts of money from individuals, etc.

Name	Type of Income or Name of Employer	How Often Received *(weekly, bi-weekly, etc.)*	Income Amount *(before taxes)*	Date Last Received

How much do you and the people in your household have in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?

Give your best estimate of the total amount: $_____

Do you and the people in your household have more than one million total dollars in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)? ☐ **No** ☐ **Yes**

Did anyone in your household leave a job or lose a job within the last 60 days?

☐ **No** ☐ **Yes** - If yes, who? _____

When? _____

For what reason? _____

Is anyone in your household on strike from a job?

☐ **No** ☐ **Yes** - If yes, who? _____

This Form Continues on the Next Page

Step 10: Tell us about the applicant's household expenses

Check all that apply. List the amount for each expense.

☐ **Child/Dependent Care Costs:**
Estimated Amount Paid per Month: $_____

☐ **Child or Spousal Support Payments Made to Someone Outside Your Household**
Estimated Amount Paid per Month: $_____

☐ **Medical Expenses for Anyone Who is Disabled or Age 60 or Older.** These include expenses such as medical bills, prescriptions, health insurance premiums, transportation to medical appointments, or other medical services.
Estimated Amount Paid per Month: $_____

☐ **Rent, Mortgage Payments, Lot Rent, Property Taxes, Homeowners' Insurance, etc.**
Estimated Amount Paid per Month: $_____

Do you or anyone in household pay for heat or air conditioning? ☐ **Yes** ☐ **No**

(check all that apply):

☐ Telephone ☐ Trash ☐ Sewage ☐ Water ☐ Electric ☐ Gas

Step 11: If applying for Early Care and Education assistance, please tell us why the applicant needs Early Care and Education assistance

If you or the people in your home are working, attending school, participating in a training program (e.g. CDL, STNA, Barber or Cosmetology) or are participating in a Substance Use Disorder program (inpatient, outpatient, AA/NA or counseling for substance use), ***please complete the table below with all qualifying activities. If you need more space, write your answers on an extra piece of paper and attach it to this form.***

Household Member 1 Name	Employer / School / Training Information Name
Activity Phone Number	Start Date / End Date
Address	

Household Member Work / School / Training Schedule- Include travel time needed

☐ Sun From _____ to _____ ☐ Thurs From _____ to _____

☐ Mon From _____ to _____ ☐ Fri From _____ to _____

☐ Tues From _____ to _____ ☐ Sat From _____ to _____

☐ Wed From _____ to _____ ☐ Varies week to week ☐ Yes ☐ No

Household Member 2 Name	Employer / School / Training Information Name
Activity Phone Number	Start Date / End Date
Address	

Household Member Work / School / Training Schedule- Include travel time needed

☐ Sun From _____ to _____ ☐ Thurs From _____ to _____

☐ Mon From _____ to _____ ☐ Fri From _____ to _____

☐ Tues From _____ to _____ ☐ Sat From _____ to _____

☐ Wed From _____ to _____ ☐ Varies week to week ☐ Yes ☐ No

Household Member 3 Name	Employer / School / Training Information Name

Activity Phone Number	Start Date / End Date

Address

Household Work / School / Training Schedule- Include travel time needed

☐ Sun From _____ to _____ ☐ Thurs From _____ to _____

☐ Mon From _____ to _____ ☐ Fri From _____ to _____

☐ Tues From _____ to _____ ☐ Sat From _____ to _____

☐ Wed From _____ to _____ ☐ Varies week to week ☐ Yes ☐ No

Step 12: Tell us about the child(ren) who need(s) Early Care and Education

Child 1 - Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth

Relationship to Applicant	Child's Preferred Spoken Language

Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive ECE Assistance.

☐ **Yes** ☐ **No** - My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care?

☐ **Yes** ☐ **No** - My child does **NOT** require Protective Child Care

If YES, is there a case plan?

☐ **Yes** ☐ **No** - My child does **NOT** have a case plan

Is the child in Head Start?

☐ **Yes** - What is their schedule? From _____ to _____ ☐ **No** - My child is **NOT** in Head Start

Is the child in kindergarten?

Yes (No)

If **YES**, is the child AM or PM or Full-day?

☐ AM

☐ PM

☐ Full-day

Program Name	Program Address	City	State	Zip Code
Barberton Preschool	633 Brady Ave	Barberton	OH	44203

Child 2

Child 2 - Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth

Relationship to Applicant	Child's Preferred Spoken Language

Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive ECE Assistance.

☐ **Yes** ☐ **No** - My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care?

☐ **Yes** ☐ **No** - My child does **NOT** require Protective Child Care

If YES, is there a case plan?

☐ **Yes** ☐ **No** - My child does **NOT** have a case plan

Is the child in Head Start?

☐ **Yes** - What is their schedule? From _____ to _____ ☐ **No** - My child is **NOT** in Head Start

Is the child in kindergarten? If **YES**, is the child AM or PM or Full-day?

Yes No

☐ AM
☐ PM
☐ Full-day

Program Name	Program Address	City	State	Zip Code

Child 3

Child 3 - Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth

Relationship to Applicant	Child's Preferred Spoken Language

Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive ECE Assistance.

☐ **Yes** ☐ **No** - My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care?

☐ **Yes** ☐ **No** - My child does **NOT** require Protective Child Care

If YES, is there a case plan?

☐ **Yes** ☐ **No** - My child does **NOT** have a case plan

Is the child in Head Start?

☐ **Yes** - What is their schedule? From _____ to _____ ☐ **No** - My child is **NOT** in Head Start

Is the child in kindergarten? If **YES**, is the child AM or PM or Full-day?

Yes No

☐ AM
☐ PM
☐ Full-day

Program Name	Program Address	City	State	Zip Code

Child 4

Child 4 - Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth

Relationship to Applicant	Child's Preferred Spoken Language

Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive ECE Assistance.

☐ **Yes** ☐ **No** - My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care?

☐ **Yes** ☐ **No** - My child does **NOT** require Protective Child Care

If YES, is there a case plan?

☐ **Yes** ☐ **No** - My child does **NOT** have a case plan

Is the child in Head Start?

☐ **Yes** - What is their schedule? From _____ to _____ ☐ **No** - My child is **NOT** in Head Start

Is the child in kindergarten?

Yes No

If **YES**, is the child AM or PM or Full-day?

☐ AM
☐ PM
☐ Full-day

Program Name	Program Address	City	State	Zip Code

Does your child(ren) who needs care have a chronic health condition, developmental disability, or special need?

☐ **No** - My child does **NOT** have a chronic health condition, developmental disability, or special need

☐ **Yes** - Please fill out the chart below:

Name *(First, Middle, Last)*	**Describe Child's Specific Needs**

This Form Continues on the Next Page

Step 13: Tell us about the school attendance of the child(ren) who need(s) care

Note: Complete this section if any child(ren) is attending or will be attending Kindergarten or higher grade school

Child's Name *(First, Middle, Last)*	Current Grade Level	School Name and Address	School Hours *(ex: 8am - 3pm)*	Kindergarten Schedule	School Year Start End Date
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	

Step 14: Please review the following information carefully and sign on the last page

BY SIGNING THIS APPLICATION:

▶ **For all programs (SNAP, Cash, ECE, and/or Medical Assistance), I acknowledge and agree:**

- To the questions on this form and certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or immigration status of each household member applying for assistance.
- The county Job and Family Services (JFS) office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of assistance and/or in some instances, I may be asked to give consent to the county JFS office to make those contacts.
- I may be required to cooperate with the child support enforcement agency (CSEA) in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the CSEA, a referral will be submitted to the agency on my behalf. I also understand that if I am not required to cooperate with the CSEA, I may request child support services by completing the Application for Child Support Services (JFS Form 07076).
- The county JFS office can assist me with getting required verifications as long as I cooperate.
- The law provides a penalty of fine or imprisonment, or both, for anyone convicted of fraudulently receiving assistance for which he or she is not eligible.
- My signature below gives the county JFS office permission to access available information in the Support Enforcement Tracking System (SETS) to verify my child/spousal/medical support income.
- The status of non-citizen household members may be subject to verification by the United States Citizenship and Immigration Services (USCIS) through the submission of information from the application to USCIS through the Systematic Alien Verification and Eligibility (SAVE) System. The submitted information received from USCIS may affect the household's eligibility and level of benefits.
- My signature below gives my consent and authorizes the county JFS office to access the Ohio Benefits Worker Portal for the purpose of verifying the citizenship status of the children in this case and for verification of the receipt of additional public assistance. I may revoke this authorization at any time by notifying the county JFS office in writing.
- You have the right to request a county conference and a state hearing if you disagree with the action taken on your case. To request a county conference you should contact your county JFS office or review your notices received in the mail.

Step 14: Please review the following information and sign (Continued)

▶ **If I applied for SNAP benefits,** I acknowledge and agree:

- By signing this application, that information will be requested from the Income and Eligibility Verification System (IEVS) and information may be verified through whatever contacts are necessary to determine my eligibility.
- Social Security Numbers (SSNs) will be used to check the identity of household members, prevent duplicate participation, and make changes to my case. If any household member does not provide their SSN, they will be designated as a non-applicant. This means they will NOT be considered as an applicant and will not be eligible for SNAP. Providing any requested information, including the SSN of each household member, is voluntary. However, failure to provide requested information to establish my eligibility for assistance will result in the denial or reduction of SNAP benefits to my household. Information collected on the application may be disclosed to law enforcement officials for the purpose of apprehending individuals fleeing to avoid the law.
- If a court of law finds me guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, I will not be eligible for benefits for two years for the first offense, and permanently for the second offense.
- If a court of law finds me guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, I will be permanently ineligible to participate in SNAP upon the first offense of such violation.
- SNAP benefits are issued on the Ohio Direction Card and I am prohibited from using my SNAP benefits to purchase or sell firearms or controlled substances. I understand that I can use SNAP benefits to only buy eligible items. I cannot use SNAP benefits to buy non-food items such as alcoholic drinks, tobacco, etc.
- Any member of my household who intentionally breaks the rules may not get SNAP for one year for the first offense, two years for the second offense, and permanently for the third offense.
- If a court of law finds me guilty of having trafficked benefits for a total amount of $500 or more, I will be permanently ineligible to participate in SNAP upon the first offense of such violation.
- I am prohibited from selling, trading or purchasing SNAP benefits and cannot use someone else's SNAP benefits for my household. I can be disqualified from the SNAP program for any of these violations.
- I cannot use benefits to buy food for someone who is not a member of my household.
- If I am found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously, I will be ineligible to participate in the SNAP for a period of 10 years.
- The information provided with my application for SNAP benefits will be subject to verification by Federal, State and local officials to determine if the information is factual and if any information is incorrect, my SNAP benefits may be denied. I may be subject to criminal prosecution for knowingly providing incorrect information.
- If I receive SNAP benefits that I should not have gotten:
    - I may be ordered to repay the benefits.
    - I may be charged with fraud.
    - I may be fined (up to $250,000) or sent to prison (up to 20 years) or both.
    - I may be prohibited from receiving benefits in the future.
- I will be held liable for any SNAP benefits that I receive that I should not have gotten if my authorized representative gives incorrect information.
- If I do not agree with an action taken on my case, I can file for a county conference or a state hearing. I can ask for a county conference or state hearing online, by email or mail, or by contacting my county JFS office. I can ask someone to attend the hearing in my place with my signed authorization.
- If my case is chosen at random to make sure that I am eligible for the assistance I receive and that I am receiving the correct amount, I must cooperate if my case is reviewed. If I refuse to cooperate with a review, my benefits may be terminated.
- Within 60 days of applying and at any time while receiving benefits, an employed or self-employed person is not to voluntarily and without good cause, quit the job or reduce work hours to less than 30 hours per week or to earning less than the federal minimum wage x 30 hours to remain eligible to participate in SNAP.

▶ **If I applied for Cash Assistance benefits,** I acknowledge and agree:

- By signing this application and receiving OWF Cash Assistance, I may be required to cooperate with the local Child Support Enforcement Agency (CSEA) in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the local Child Support Enforcement Agency (CSEA), a referral will be submitted to the agency on my behalf and any rights to all support owed to me and the minor children in the assistance group will be assigned to the State of Ohio.

Step 14: Please review the following information and sign (Continued)

- By signing this application and receiving OWF Cash Assistance, I am assigning to the State of Ohio any rights to child or spousal support that is owed to me and/or the minor children in the assistance group during the Ohio Works First eligibility period.
- Cash benefits are issued on the EPPICard™. The EPPICard™ can be used at MasterCard member banks, ATMs and most retailers that accept MasterCard. I cannot use my EPPICard at liquor stores, casinos, gaming establishments, or any retail establishments that provide adult entertainment in which performers disrobe or perform in an unclothed state for entertainment purposes.
- I must activate my EPPICard™ within 90 days from when benefits and my first card is issued and that if my EPPICard™ is not activated within 90 days, my benefits will be removed from my account.

▶ **If I applied for Early Care and Education (ECE),** I acknowledge and agree:

- My county JFS office or DCY may share approval, denial, and submission status of my application to the program(s) listed on this application or to any program named as a result of a change to my application.
- I understand that the sharing of this information to any program not listed on this application shall require the signing of a separate release per Ohio Revised Code.
- I will be able to use ECE only for children who are eligible and only up to the maximum hours authorized by the county JFS office. To remain eligible for PFCC benefits, the required copayment (if applicable) must be paid by me to the program. Failure to pay the required copayment may result in termination of PFCC benefits.
- If I am approved for services, I will be responsible for accurately recording my child's attendance at the program by utilizing an automated attendance tracking system. This includes registering in the system and creating personal identification information that I will use to access the system and to serve as my electronic signature. I understand that my program is not permitted to record my child's attendance on my behalf and may not have access to my personal identification information. I understand that the attendance tracking system may take my photo or a photo of my designee/sponsor as part of the login and logout process. I understand that I am responsible for approving any changes that my program makes in the attendance tracking system regarding my child's attendance at the program.
- If my child attends a Step Up To Quality rated program, and if an assessment is completed on my child, the data will be collected and reported to DCY.
- I have received an explanation regarding the requirements for determining eligibility, the reasons why I may not be eligible, my right to a state hearing, and my responsibility for reporting changes to the county JFS office and the penalty, including possible civil action or criminal prosecution, for the intentional withholding or falsification of information or misuse of benefits, including misuse of the automated child care attendance tracking system.
- I must report any changes which affect my PFCC eligibility to the county JFS office, including changes in my income goes above 300% of the federal poverty level, long-term changes in participation in my qualifying activity and address changes. I understand that I must report changes within 10 days of the date they occur.
- My signature also gives consent to issue a system generated statewide student identifier (SSID) for each child listed on this application.
- Information About ECE Programs:
    - Parents may select any program approved to offer ECE. These programs include centers, family child care homes, preschools, school-age care, in-home aides and child day camps located throughout the state of Ohio
    - If you would like assistance with selecting a program, you may contact your local Child Care Resource and Referral Agency.
    - You may use our Child Care Directory to look for programs that fit your child care needs at *https://childcaresearch.ohio.gov.* The directory allows you to search by location, type of program, services offered and days and hours of operation. Information is provided about each program including Step Up To Quality rating, any additional accreditation or affiliation, licensing inspections and substantiated complains.
    - Step Up To Quality helps families choose programs that go beyond the minimum standards of licensing. Rated programs demonstrate higher levels of quality in a variety of ways. If you would like more information about the Step Up To Quality program, visit the DCY website at *https://childrenandyouth.ohio.gov/for-providers/step-up-to-quality.*
- You may also visit our website to learn more about Medicaid health screenings and early intervention services for your child. For this information, go to Healthchek | Medicaid and https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/healthchek and for Early Intervention services go to https://ohioearlyintervention.org/.
- If you would like to make a complaint about a suspected violation of licensing rules, misuse, or fraud you may contact the Family and Customer Support Center at 1-844-234-5437.

▶ **If I applied for Medical Assistance benefits,** I acknowledge and agree:

- Under penalty of perjury, I have disclosed all annuities and other similar financial devices in which I and/or my spouse have any interest.
- By signing this application and receiving Medicaid, I am assigning to the State of Ohio any rights to medical support and any rights to payments by a liable third party for medical assistance owed to me and/or to the minor child(ren) in my assistance group. I understand that I must tell the Ohio Department of Medicaid about any health insurance I have or about any third party responsible for my medical expenses. I give the Ohio Department of Medicaid the right to pursue medical support from an ex-spouse or parent. If I think that cooperating to collect medical support will harm my child(ren) or myself, I understand that I can tell the Ohio Department of Medicaid and I may not have to cooperate.
- That the Ohio Department of Medicaid will check my answers using Social Security numbers and information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Department of homeland security (DHS), and others. If the information does not match, the Ohio Department of Medicaid may ask me to send more information.
- The Ohio Department of Medicaid will get information about my financial resources from banks, credit unions, or other financial institutions to determine my eligibility for medical assistance. Authorization to get this information remains in effect until:
  - My application for medical assistance is denied; or
  - My eligibility for medical assistance ends; or
  - I inform the Ohio Department of Medicaid in writing that I wish to end my authorization.
- If I refuse to authorize the Ohio Department of Medicaid to get information about me from financial institutions, or I decide to end my authorization for the Ohio Department of Medicaid to get information about me from financial institutions, I understand that my medical assistance may be denied or discontinued.
- If I am permanently institutionalized or age 55 or older when I receive Medicaid benefits, after my death the Estate Recovery Program may recover payments for the cost of my care paid by Medicaid from my estate. The cost of my care may include the capitation payment that Medicaid pays to my managed care plan, even if the capitation payment is greater than the cost of the services I actually received.
- I authorize any person who furnishes health care, medical supplies, or services to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Medicaid program, WIC, and other medical assistance programs. I understand that I authorize the previously mentioned departments to exchange any information I have provided to enable the departments to determine my eligibility for medical assistance benefits.
- The Medicaid Program requires enrollment for most recipients into a Managed Care Plan. You will receive information in the mail about this if you are determined eligible for Medicaid.
- The Healthchek program offers preventative healthcare services to all Medicaid eligible children under the age 21 and pregnant woman. A Medicaid eligible child may receive free Healthchek screenings for vision and hearing.

I authorize _____ to be my representative for _____ program.

(Name of Auth Rep) *(Ex. SNAP, OWF)*

For Medicaid: You may be asked to provide further documentation of the authorization in order to comply with OAC 5160-1-33.

- If you need more than one authorized representative, please contact your county JFS office.

Signature of Applicant OR Authorized Representative	**Date**
Print Name of Applicant OR Authorized Representative	**Date**

- END OF APPLICATION -

Turn this application in to your local County JFS Office

Please refer to the insert for the address for your local County Department of Job and Family Services.