Reset Form

AGENCY USE ONLY	Case Name	Case Number	Date Mailed/Picked Up	Date Returned To CDJFS	Unique ID

APPLICATION FOR HELP WITH MEDICARE EXPENSES

Medicaid can assist you in paying costs that are 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-1 (QI-1), Qualified Individuals-2 (QI-2), or Qualified Working Disabled Individuals (QWDI) categories of Medicaid. Please complete this application to apply for or to continue receiving this type of assistance.

- A face-to-face interview is not required.
- You must supply proof of identification, citizenship, age, income & resources.
- This is not an application for cash assistance, regular Medicaid, or food stamps.
  If you wish to apply for any other kind of help, please call your county department of job and family services.

If you have questions, please call the MEDICAID CONSUMER HOTLINE at 1-800-324-8680 or TDD 1-800-292-3752.

You may use the blank areas at the bottom of the pages if you need more space to answer any question.

1. Name of person applying (PRINT)	2. Phone number where you can be reached	3. Your Social Security Number	4. Social Security Claim Number

5. Street Address	6. City	State	7. Zip	8. Is the Medicare Part B premium being taken out of your Social Security Check? ☐ YES ☐ NO Date it began: _____
		OH		

9. Date of birth	10. Place of birth	11. Are you a US Citizen? ☐ YES ☐ NO If you answered NO, you will be asked to show an alien registration card & INS forms.	12. Race/ethnic affiliation (optional): ☐ Black/not of Hispanic origin ☐ White/not of Hispanic origin ☐ Hispanic ☐ American Indian ☐ Asian/Pacific Islander ☐ Other

13. Martial status: ☐ SINGLE ☐ MARRIED ☐ WIDOW(ER) ☐ DIVORCED If you are married or have been married, list the following information about each spouse.

NAME: _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

What is your spouse's source(s) of income? _____ Gross amount per month? $_____

IF YOU ARE MARRIED, DOES YOUR SPOUSE GET MEDICARE? ☐ YES ☐ NO - DOES HE/SHE WANT HELP WITH MEDICARE EXPENSES? ☐ YES ☐ NO - IS THIS APPLICATION ALSO FOR HELP FOR YOUR SPOUSE? ☐ YES ☐ NO

14. Have you received cash, Medicaid, or food stamp assistance in the past? ☐ YES ☐ NO If you answered YES, please explain where, when & the kind of assistance you received. _____

15. Tell us about your income. Where does it come from? How much do you receive? How often? List all of your income from all sources such as Social Security, SSI, VA benefits, alimony, employment or other type(s) of income like money from friends & family received on a regular basis.

TYPE OF INCOME	GROSS AMOUNT	HOW OFTEN
	$	
	$	
	$	

16. List all of your current resources of assets. Be sure to list any of these items that you (or your spouse) may own. List the account numbers and the current balance(s).

Savings accounts	Stocks/bonds	401Ks	Money market funds	Keough plans
Checking accounts	Tax shelter accounts	Trust funds	Life insurance	Revocable burial accounts
Credit union	Certificate of deposits	Christmas clubs	Land contracts	Irrevocable burial accounts
Promissory notes	Automobiles	Other vehicles	IRAs	Other asset(s) (Describe)

TYPE OF RESOURCE	ACCOUNT/POLICY NUMBER	VALUE	NAME OF BANK, INSURANCE COMPANY, ETC.
		$	
		$	
		$	

Use this space for additional information.

17. Do you own all or part of any real estate in which you do not live? This includes houses, vacant land, farm land, and business property. ☐ YES ☐ NO
If you answered YES, tell us about the property. (Do not list the house where you live.)

Address: _____ Value: $_____

Address: _____ Value: $_____

18. Do you any other health insurance coverage? ☐ YES ☐ NO If you answered YES, please supply the following information:

Name of insurance company/plan: _____ Policy number: _____ Monthly cost: $_____

19. Would you like to have your eligibility for help with your Medicare expenses explored for the past three months? ☐ YES ☐ NO
If your answer is YES, Please enclose or attach verification of your income for each of the three months.

20. Do you expect any changes in the next 12 months to your household including the people you live with, the amount of money you (or your spouse) receive, a change in your resources, or other changes in circumstances you described when answering the questions on this application? ☐ YES ☐ NO
If you answered YES, what changes do you expect?

_____

_____

21. You may name someone to be your authorized representative. This person must be at least 18 years old. He/she will be able to act in your behalf with regard to your application and all other actions concerning your case. This person may be a friend, relative, neighbor, or legal representative. You may choose an authorized representative at a later date if you do not wish to name one now. Do you want to name an authorized at this time? ☐ YES ☐ NO
If YES, please provide information about your authorized representative.

Name of authorized representative _____	Age _____
Address of authorized representative _____	Phone number (_____) _____

Use this space for additional information.

Please read page 4 of this application carefully. The application must be signed and dated by you or your authorized representative.

PLEASE READ CAREFULLY

Your rights and responsibilities as a Medicaid applicant or consumer are described below.

I affirm that I have read my rights and responsibilities or they have been read to me. I understand them and I have been provided with a copy of these rights and responsibilities for my personal records. I also affirm that I have answered these questions correctly and to the best of my abilities. I agree to fulfill my responsibilities as described. I agree to provide proof of eligibility, if proof is requested.

I authorize any person who furnishes me with health care or medical supplies to give the Ohio Department of Job and Family Services (ODJFS) any information related to the extent, duration, and scope of services provided to me by Medicaid. This information includes, but is not limited to: claim forms, patient medical records, records showing information about office visits, laboratory tests, procedures, and treatments as well as my program eligibility.

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

I understand that the law provides penalty of fine and/or imprisonment for anyone convicted of accepting assistance for which he or she is not eligible. I state under penalty of perjury that all of the information in this application is true and complete to the best of my knowledge.

My signature below means that I have been given a copy of "Your Rights & Responsibilities As A Consumer of Medicaid Health Coverage" (JFS 07236 or JFS 07236-S/Spanish Version). I understand I may call the county department of job and family services if I have questions about my rights and responsibilities.

APPLICANT X_____ **DATE X**_____

Authorized representative's signature (if applicable) _____ **DATE X**_____

Witness' signature (if signed with an "X") _____ **DATE X**_____

Signature of person who helped complete the application (if applicable): _____ **DATE X**_____

Use this space for additional information.

PLEASE CHECK TO MAKE CERTAIN THAT YOU HAVE ANSWERED ALL QUESTIONS CORRECTLY.
AN INCOMPLETE APPLICATION CAN DELAY THE DETERMINATION OF YOUR ELIGIBILITY.