RETROACTIVE MEDICAID COVERAGE APPLICATION

For Agency Use Only: ☐ ADC-Related Medicaid ☐ Medicaid

Assistance Group Name ______________________ Assistance Group # ______________________

RETROACTIVE COVERAGE PERIOD: 1. ______________ 2. ______________ 3. ______________

A.

Address ____

Street City State Zip

Did you live at this address during the month(s) for which medical assistance is requested? ☐ Yes ☐ No

If no, please provide previous address: ____

____

B.

Did the same people live with you during the three-month period as was reported on your application? ☐ Yes ☐ No

If there were different people living with you, please list their names, relationship to you, and their age.

NAME	RELATIONSHIP	AGE

C.

During the three-month period, was your income the same as reported on your application? ☐ Yes ☐ No

If no, please explain how it differed: ____

____

D.

Resources (During retroactive coverage month(s):	Month #1	Month #2	Month #3
Cash			
Checking account			
Savings account			
Certificate of deposit			
Trust fund			
Stocks/bonds			
Burial account/trust			
Tax shelter account			
Vehicles			
Life insurance			
Real property			
Other			

E.

Medical bills [List all medical expenses incurred during retroactive covered month(s):]

Person Who Received Care	Medical Provider: (Who Provided the Care)	Date of Service	Monthly Payment	Balance Due

For Agency Use Only:

Comments:

JFS 07110 (Rev. 11/2000)
(Formerly ODHS 7110)

IMPORTANT
YOUR RIGHTS AND RESPONSIBILITIES

Read this page before you sign your name.

Quality Control Review
Persons receiving public assistance and/or food stamps may be subject to a quality control review conducted by the Ohio Department of Job & Family Services (ODJFS) to determine the correctness of eligibility and payments. I understand that I must cooperate if my case is selected.

Right to a State Hearing

You have a right to a state hearing before the Ohio Department of Job & Family Services if:

- You do not receive financial or medical assistance, or written notice of the decision on your application within 45 days from the date you applied.
- You disagree with the decision made on your application or with the type or amount of benefits you received.
- You disagree with a proposed action to reduce, suspend, or stop your benefits.
- A change in your benefits is made without written notice explaining the reason for the change and giving you an opportunity for a hearing.

You also have the right to request a county conference to discuss your case informally with an employee of the county department of job & family services.

For a complete explanation of your hearing rights and the hearing process, please read "Explanation of State Hearing Procedures", ODJFS 04059. A copy of the ODJFS 04059 should be given to you along with this application form.

Reporting Responsibilities for Public Assistance

You are responsible at all times for giving complete and correct information regarding your situation. You must report to the CDJFS, within ten calendar days, any:

- Change of address.
- Change in living arrangement.
- Change in members of your household.
- Changes in your assets or property ownership.
- Changes in your amount of income or changes in your sources of income.
- Payment of bills by sources other than the Ohio Department of Job & Family Services.
- Whenever a child 16 years old or older quits school.
- Change in living expenses.

Automatic Assignment of Third Party and Medical Support Payments

When you accept aid in the form of Medicaid, you agree to transfer your right, and those individuals you are legally responsible for, to collect and retain third party medical payments to ODJFS. A third party is any private medical insurer, individual, entity, or public or private medical program that is or may be liable to pay all or part of the cost of medical care. Medicare benefits are not affected by this provision.

You must cooperate with ODJFS and CDJFS in establishing paternity and obtaining third party payments. You (or your representative) must tell the CDJFS.

- About any third party medical coverage which you have or may be available.
- When you and/or family members are attempting to recover money or when money has been recovered because of an injury, disease, or disability.
- If you and/or family members receive a third party payment directly. You may have to repay ODJFS if the third party payment is for services which are paid by Medicaid on your and/or family members behalf.

Refusal to cooperate in establishing paternity and obtaining third party payment will result in your ineligibility for Medicaid.

ODJFS will only collect and retain third party payments up to the amount of medical expenses which the Medicaid program pays on your behalf. If you become ineligible for Medicaid, your rights to future third party payments will be immediately restored. However, the transfer of your third party collection right to ODJFS remains in effect for the time period during which you were on assistance.

Release of Medical Information

I hereby authorize any person who furnished me with health care or supplies to give the Ohio Department of Job & Family Services any information related to the extent, duration, and scope of services provided to me under the Medicaid program. In addition to information shown on claim forms, such information may include but is not limited to patient history, patient medical records, and records showing the date, time, and length of office visits, tests, or treatment.

SIGNATURE

I received a copy of and I have read all of my rights and responsibilities or they have been read to me, and I understand them. I understand and agree to fulfill my responsibilities as described. I agree to provide proof of my need if such proof is requested. I give my consent to the agency to make whatever contacts are necessary to determine my eligibility for public assistance. I also 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 these answers are complete and correct. I understand the law provides penalty of fine or imprisonment for anyone convicted of accepting assistance for which he or she is not eligible. I state under penalties of perjury that all the information on this application is true and correct to the best of my knowledge.

Signature of Applicant/Recipient	Date of Signature
Signature of Person who Completed this Form or Helped Complete this Form	Date of Signature
Signature of Agency Witness	Date of Signature
Signature of Witness *(If an "X" is used, two witnesses need to sign below)*	Date of Signature
Signature of Witness	Date of Signature