MAGI Medicaid Renewal Information

Case Number: OB: _____ CRISE: _____
Case Name: _____ Renewal Month: _____
Caller's Name: _____ Caller's SSN: _____
Date of Call: _____ Phone #: _____
Address: _____
Voter Registration: Would you like a voter registration form to be mailed to you? Yes No

Household Member Name:				
Monthly Income Amount:				
Income Type:				
Employer Name:				
Pregnant?	Yes No	Yes No	Yes No	Yes No
If Yes, Due Date:				
Other Insurance?	Yes No	Yes No	Yes No	Yes No
If Yes, Type: (Need front/back copies)				
How will you file your taxes?	Single Married Filing Jointly Married Filing Separately Not Filing	Single Married Filing Jointly Married Filing Separately Not Filing	Single Married Filing Jointly Married Filing Separately Not Filing	Single Married Filing Jointly Married Filing Separately Not Filing
Who do you claim as dependents?				
Is someone who is not living in the household claiming anyone?				
If Yes, list the name of the tax filer and their relationship to you.				

By signing and/or giving your verbal permission below, each adult member of the household understands that South Central Ohio JFS will need the above information to check eligibility for Medicaid. We may check your answers using information in our electronic databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to provide further verifications. **Do you give permission to Ping Hub? Yes / No 1 Year 2 Years 3 Years 4 Years 5 Years**

Primary Applicant (18 years & older) Printed Name: _____
Date: _____