Reset Form

Ohio Department of Medicaid

REFERRAL FOR MEDICAID CONTINUING ELIGIBILITY REVIEW

IV-E Agency to County Department of Job and Family Services

Section I: Information about referred individual

First Name	M.I.	Last Name		
Social Security Number	Date of Birth	Sex ☐ Male ☐ Female	Is this individual disabled? ☐ Yes ☐ No	
Street Address, Apt. No.	City	State	Zip Code	County
Home Telephone	Custody of IV-E Agency? ☐ Yes ☐ No	Date Medicaid under PCSA ends		
Did individual age out of foster care at age 18? ☐ Yes ☐ No	In receipt of IV-E services (FCM / Independent Living Services) before 18th birthday (Please specify)	Has citizenship been verified by PCSA? ☐ Yes ☐ No		
Reason for Termination				

If the individual listed is aging out of foster care, skip sections II and III, continue to IV. Assist the individual in completing a ODM 07216 and 07236, then forward all forms to the local county department of job and family services.

If the individual listed is not aging out of foster care, please continue with sections II, III, and IV below.

Section II: Living arrangement information

First Name **(Parent/Caretaker #1)**	M.I.	Last Name	
Date of Birth	Sex ☐ Male ☐ Female	Receives Medicaid health coverage, OWF or Food Stamps ☐ Yes ☐ No ☐ Unknown	
Case Number (if known)	Race/Primary Language	Social Security Number (if known)	
Relationship to referred individual			

First Name **(Parent/Caretaker #2)**	M.I.	Last Name	
Date of Birth	Sex ☐ Male ☐ Female	Receives Medicaid health coverage, OWF or Food Stamps ☐ Yes ☐ No ☐ Unknown	
Case Number (if known)	Race/Primary Language	Social Security Number (if known)	
Relationship to referred individual			

Section III: Income Information.

If known, complete lines below for referred individual and parents(s)/caretaker(s) who have earned or unearned income from any source, such as: wages, self-employment, social security, SSI, VA pension, workers compensation, alimony, or child support.

Name	Employer or Income Source	Gross Amount	How Often Received
1.		$	
2.		$	

Section IV: Other Health Insurance Information.

If the individual has other health insurance or a medical support order, please document below.

Insurance Company	Policy Number	Monthly Premium

Signature of IV-E Agency Representative:

By signing this document, the PCSA affirms it has verified and properly documented U.S. citizenship in accordance with Chapter 5101:1-38 of the Administrative Code. The PCSA also affirms it has conducted a pre-termination review, and has issued proper notice and hearing rights to the affected IV-B or IV-E foster child identified on this form, in accordance with Chapter 5101:1-38 and rule 5101:6-7-02 of the Administrative Code, respectively.

Eligibility Worker	Title, Agency	Telephone Number	E-mail	Date