Reset Form

Ohio Department of Job and Family Services

RETROACTIVE MEDICAID WORKSHEET

This form is not an application, but is used to gather information used to determine whether you were eligible for Medicaid in the three months before your application.

First Name	MI	Last Name		Medicaid billing # or SSN
Street Address, including Apt. #		City	Zip	County
If you have moved during the last 3 months, please give your last address				

For the last three months, have you lived with the same people who are named in your application? ☐ Yes ☐ No

If not, please list:

People who lived with you, not listed in application			People in the application who didn't live with you before		
Name	**Relationship to you**	**Age**	**Name**	**Relationship to you**	**Age**

In the last three months, have your income or resources changed?

Month	Change to	What changed?
	☐ Income ☐ Resources	
	☐ Income ☐ Resources	
	☐ Income ☐ Resources	

Please tell us about medical care your family received during the last three months.

Who was examined or treated?	Medical provider (Who provided the care?)	Date of Treatment or Exam