

Ohio Department of Medicaid
MEDICAID APPROVAL NOTICE IN CASES WITH COMMUNITY SPOUSE

Institutionalized Spouse's Name	Community Spouse's Name	Mailing Date										
Street Address	Street Address	Case Number										
City, State, Zip Code	City, State, Zip Code	County										
<p>This notice tells you about a determination the county department of job and family services made on your case. If you do not understand this determination, contact your eligibility worker.</p> <p>Your Medicaid application for long-term care coverage dated _____ is APPROVED effective _____</p>												
Reason for Approval												
Ohio Administrative Code rules supporting this approval												
<p>Attached to this letter are several forms:</p> <ul style="list-style-type: none"> • ODM 04076 "Resource Assessment Worksheet" This form determines the total amount of combined resources available to the institutionalized spouse and community spouse as of the date of institutionalization. • ODM 04077 "Resource Transfer Worksheet" This form determines the amount of resources that are attributed to each individual. • ODM 04078 "Monthly Income Allowance (MIA) Computation Worksheet" This form determines the amount of monthly income the community spouse may receive from the institutionalized spouse. • ODM 04206 "Family Allowance (FA) and Family Maintenance Needs Allowance (FMNA) Computation Worksheet", if applicable. This form determines the amount of income dependent family members may receive. <p>The following determinations are made from these forms:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">1. Resources allocated to the community spouse</td> <td style="width: 30%; text-align: right;">\$</td> </tr> <tr> <td>2. Resources allocated to the institutionalized spouse</td> <td style="text-align: right;">\$</td> </tr> <tr> <td>3. Minimum monthly maintenance needs allowance</td> <td style="text-align: right;">\$</td> </tr> <tr> <td>4. Gross countable income of the community spouse (includes income from the institutionalized spouse and income generated from resources)</td> <td style="text-align: right;">\$</td> </tr> <tr> <td>5. Family Allowance/Family Maintenance Needs Allowance</td> <td style="text-align: right;">\$</td> </tr> </table>			1. Resources allocated to the community spouse	\$	2. Resources allocated to the institutionalized spouse	\$	3. Minimum monthly maintenance needs allowance	\$	4. Gross countable income of the community spouse (includes income from the institutionalized spouse and income generated from resources)	\$	5. Family Allowance/Family Maintenance Needs Allowance	\$
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Eligibility Worker	District ID	Telephone Number										

Ask For a State Hearing If You Want to Appeal

Ask for a state hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Job and Family Services will decide who is right.

If you want to a hearing, we must receive your request within 90 days of the mailing date on this notice.

Someone else may help you (a lawyer, social worker, friend, relative, etc). Someone else may request a hearing for you and come to the hearing with you.

You can ask your local Legal Aid program for free help with your case. Contact your local Legal Aid office by phoning 1-866-LAW-OHIO (1-866-529-6446) or by searching the Legal Aid directory at <http://www.ohiolegalservices.org/programs> on the internet.

Federal law requires us to keep your health information private. This includes all of the information we have about your health, the health care you get, payments Ohio Medicaid makes for your health care, etc. Our "HIPAA Privacy Notice" tells you more about your privacy rights under the law. You may get a copy of the notice by calling the Ohio Medicaid Consumer Hotline toll-free at (800) 324-8680 or by visiting our web site at www.jfs.ohio.gov/hipaa/privacy.pdf. The law is the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you want to request a state hearing, follow the directions below. If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

State Hearing Request		
<p>Sign and fill in the blanks. I think this policy is being incorrectly applied to me. I want a state hearing.</p>		
Sign Here	Date	Phone
<p>Complete this if someone else has already agreed to represent you (a lawyer, social worker, friend, relative, etc). If someone later agrees to represent you, tell us then.</p>		
Name	Fax	
Address	Phone	
City, State and Zip Code	E-Mail	
<p>Choose one of these ways to send this request to us:</p> <p>If you want a hearing, mail a copy of this page to the Ohio Department of Job and Family Services, Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.</p> <p style="text-align: center;">OR</p> <p>Fax only this side of this form to (614) 728-9574 (ODJFS, Bureau of State Hearings).</p> <p style="text-align: center;">OR</p> <p>E-mail to bsh@jfs.ohio.gov (please include your name, address, case number, and tell us why you are requesting a hearing).</p> <p style="text-align: center;">OR</p> <p>Phone the ODJFS Customer Access Line at 1-866-ODJFS-4-U (1-866-635-3748) and follow instructions for state hearings. Only you may call.</p>		