BUTLER COUNTY DEPARTMENT OF JOB & FAMILY SERVICES
FOOD ASSISTANCE, CASH ASSISTANCE AND MEDICAID REDETERMINATION REVIEW PACKET

The Butler County Department of Job & Family Services (BCDJFS) is required by law to mail you the following information for the upcoming review of your food assistance, cash assistance and/or Medicaid benefits. Please see the below chart to determine which of the forms contained in this packet you need to complete and return to BCDJFS based on the benefits you are currently receiving.

Forms must be returned within **10 days** of the receipt of this packet. You may return your packet by e-mail, fax or mail to the numbers/address located at the bottom of this page.

Some forms require verification of income, resources, expenses, etc. A chart is located on Page 2 outlining this information. In addition, if you are receiving food and/or cash assistance, please see Page 2 for information about a mandatory phone interview.

The below chart will assist you with which forms you need to complete for the services you are receiving. Column 1 lists forms required for food assistance, column 2 lists forms required for cash assistance and column 3 lists forms required for Medicaid. If you are receiving more than one service that requires the same forms, you only need to fill them out once.

Failure to return the requested forms and/or verification(s) will result in unnecessary delays and termination of your benefits.

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Page 3 Public Assistance Fraud Warning **(OPTIONAL TO COMPLETE & RETURN)**		
Pages 4 - 5 Cash, Food Assistance and/or Medicaid Eligibility Review Form **(REQUIRED TO COMPLETE & RETURN)**	**Pages 4 - 5** Cash, Food Assistance and/or Medicaid Eligibility Review Form **(REQUIRED TO COMPLETE & RETURN)**	**Pages 4 - 5** Cash, Food Assistance and/or Medicaid Eligibility Review Form **(REQUIRED TO COMPLETE & RETURN)**
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Pages 12 -14 Voter Registration and Notice to Rights and Declination **(OPTIONAL TO COMPLETE & RETURN)**	**Pages 12 -14** Voter Registration and Notice to Rights and Declination **(OPTIONAL TO COMPLETE & RETURN)**	**Pages 12 -14** Voter Registration and Notice to Rights and Declination **(OPTIONAL TO COMPLETE & RETURN)**

COUNTY COMMISSIONERS
CINDY CARPENTER
DONALD L. DIXON
T.C. ROGERS

BUTLER COUNTY DEPARTMENT OF JOB & FAMILY SERVICES
315 HIGH STREET, 8TH FLOOR, HAMILTON, OHIO 45011
PHONE: 513.887.5600 • FAX: 513.887.4334
E-MAIL: VERIFICATIONS@JFS.OHIO.GOV
VISIT US ON THE WEB: WWW.BUTLERCOUNTYOHIO.ORG/WORKPLACE

CASH/FOOD ASSISTANCE RECIPIENTS

If you are receiving food and/or cash assistance which requires a phone interview, you will receive a separate letter from the Ohio Department of Job & Family Services with the date and time of the phone interview. Appointment letters will be mailed on the 15th of every month for the next month's re-certification. This notice will include the phone number we have on record for you. If this number is not correct, please call us immediately to report the correct number. You are still required to fill out the forms located under food and/or cash assistance in the chart on Page 1 and they should be returned prior to your scheduled appointment date.

SCHEDULED APPOINTMENT TIME	WHEN YOU WILL BE CALLED
7:20 a.m.	Between 7:20 a.m. & 9:00 a.m.
9:20 a.m.	Between 9:20 a.m. & 11:00 a.m.
12 (noon)	12 (noon) & 1:10 p.m.
1:15 p.m.	1:15 p.m. & 2:00 p.m.

VERIFICATION CHECKLIST

Depending on the service(s) you are receiving, the form you are filling out may require you to submit verification of income, resources, expenses, etc. The below chart outlines the verification categories and what types of documentation can be used in each of those categories.

Income • Earned income verification (pay stubs, self-employment records, tax records, etc.) • Unearned income verification (SSI, SSA, VA, UC, child support, award letters, etc.)	**Resources (Only for Medicaid for the Aged, Blind & Disabled)** • Recent bank account statements (savings, checking, credit union, etc.) • Proof of current value of stocks/bonds, certificates of deposit, life insurance, trusts and annuities
Expenses • Proof of shelter expenses if there has been a change • Proof of utility expenses if there has been a change • Proof of child care costs • Proof of child support you pay to another household	**Other** • High school & college attendance verification • Pregnancy verification from a doctor or nurse (due date and number of fetuses) • Private health insurance card (front & back)

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PUBLIC ASSISTANCE FRAUD WARNING

The Butler County Department of Job & Family Services, Butler County Commissioners and Butler County Prosecutor's Office want to ensure that everyone receives accurate food assistance (SNAP) benefits.

Any person who misrepresents themselves, any other person, or any information in order to receive food assistance (SNAP) benefits will be prosecuted to the fullest extent of the law.

Under penalty of law, I agree that all of the questions that I will answer are true. All of the information that I will give during my food assistance (SNAP) benefit interview will be an exact representation of the entire household situation.

I also understand that if I am found guilty of fraud, I can be fined up to $250,000, sent to prison for up to 20 years, or both, and disqualified from participation in the food assistance program from 1 year to permanently.

Authorized Representatives

* You may appoint someone to act for you to do any or all of the following:
    - Apply for benefits on your behalf;
    - Receive and use your assistance group's benefits on your behalf and for your benefit;
    - Report changes on your behalf.
* If you are a resident in a drug or chemical dependency treatment center, the center must be appointed as your authorized representative.
* The authorized representative must be an adult, who is not an employee of this agency, is not a disqualified individual from our programs, and is not a homeless meal provider or a food assistance retailer.
* Before the appointment, change, or revocation of an authorized representative can become effective, you must submit a signed request on form BCDJFS 233 or a written letter with the same essential information. This form (or its equivalent) must be signed and dated by you and must also be signed and dated by the authorized representative, acknowledging their rights and responsibilities in acting on your behalf, as well as their receipt of the written rights and responsibilities.
* This written declaration must be filed with the county agency before the appointment of an authorized representative takes effect, even for an emergency or temporary appointment.

Food Assistance / SNAP / EBT Benefits Usage

Food Assistance (SNAP) benefits are issued to you electronically and you can access them through the use of an electronic benefit transfer (EBT) card which is or has been issued to you for your use. The only proper use of these benefits is for you, an adult member of your assistance group, or your authorized representative to purchase eligible foods from a retailer authorized by the U.S. Department of Agriculture, Food & Nutrition Services, for preparation and consumption by you and your assistance group only. Any other possession, buying, selling, usage, alteration, acceptance, or transfer of these benefits or the EBT card is a violation of the Food & Nutrition Act of 2008. The EBT card itself remains state property and any violation of the foregoing, or possession of a reported lost or stolen card, can result in its seizure by the proper authorities, even if it is your card.

_____ _____

Applicant / Recipient / Authorized Representative Signature Date

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CASH, FOOD ASSISTANCE AND MEDICAID ELIGIBILITY REVIEW FORM

THIS FORM MUST BE COMPLETED & RETURNED WITHIN **10 DAYS** OF THE DATE YOU RECEIVE THIS PACKET.

Name:		SS#:	Case #:
Address:	City:	State:	Zip Code:

PLEASE COMPLETE THE SECTIONS THAT APPLY TO YOUR HOUSEHOLD

HOUSEHOLD MEMBERS: (List **all** current household members below.)

Name	Date of Birth	SS#	Relationship to You

RESOURCES:

Does anyone have any resources? ☐ Yes ☐ No (If yes, check all that apply below.)
Verification will be required for certain Medicaid categories (Aged, Blind & Disabled)

☐ Vehicles	☐ Dividends/Interest	☐ Annuities	☐ Cash
☐ Checking	☐ Savings	☐ Retirement Accounts	☐ Mutual Fund
☐ Credit Union	☐ Trusts	☐ Sold a resource	
☐ Burial/Funeral Contract	☐ Life Insurance	☐ Property you are not living in	
☐ Received a lump sum	☐ Stocks/Bonds	☐ Other resource (specify):	

UNEARNED INCOME: (i.e., child support, unemployment comp., social security, workers' comp., etc.)
Does anyone receive unearned income? ☐ Yes ☐ No (If yes, complete below.) **VERIFICATION REQUIRED.**

Name	Income Source	How Often Received	Total Gross Amount	Date of First Payment	If ended, date of last payment

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EARNED INCOME: (employment/self-employment) **VERIFICATION REQUIRED.**
Is anyone employed or self-employed? ☐ Yes ☐ No (If yes, complete below.)

Name	Employer	How Often Received	Total Gross Pay	Date of First Pay	If ended, date of last pay

HEALTH INSURANCE: VERIFICATION REQUIRED.
Is anyone covered on other health insurance? ☐ Yes ☐ No (If yes, complete below).

Name of Covered Member(s):	Name of Health Insurance	Cost of Health Insurance

CHILD CARE EXPENSES/CHILD SUPPORT EXPENSES: VERIFICATION REQUIRED.
Does anyone pay child care of child support? ☐ Yes ☐ No (If yes, complete below).

Name(s) of member who pays child care expenses:	Nam of member(s) who pays child support:

YOUR SIGNATURE: My answers on this form are correct and complete.

Signature:	Date:	Phone #:

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Ohio Department of Job and Family Services

REQUEST TO REAPPLY FOR CASH AND FOOD ASSISTANCE

VOTER REGISTRATION APPLICATION ATTACHED – ASSISTANCE AVAILABLE

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ YES, I want to register to vote.
☐ NO, I do not want to register to vote.

If you do not check either box, you will be considered to have decided not to register to vote at this time.

Case Number		
County Contact	County Contact Phone Number	County Contact Fax Number

Step 1: Read the information in this box, and make corrections as necessary.

First Name, Middle Initial and Last Name					
Mailing Address			Street Address (if different)		
City	State	Zip Code	City	State	Zip Code

Step 2: Please read this information carefully.

To continue to get your benefits we must review your case to ensure that you are still eligible and that you are receiving the correct amount of benefits.

Please sign and return this form to us before your appointment date _____ but no later than _____. Return this form to your county agency or the fax number listed above or complete it online at: https://odjfsbenefits.ohio.gov. If we do not receive this form your cash assistance will be terminated and your food assistance will expire.

Remember reapplying for benefits has two steps: 1. Signing and returning this form and 2. Completing an interview.

If we do not receive this form by the deadline, your cash assistance will be terminated and your food assistance will expire.

Medical assistance: This form is not an approved application for medical assistance programs. Consumers should continue to reapply using approved medical assistance application forms. Any information provided during your telephone interview will be used to update your case and may affect your medical assistance benefits.

Step 3: Please read, complete, and sign the sections below.

By signing this form:

- I understand and certify, under penalty of perjury, that all my answers for the reapplication interview are correct and complete to the best of my knowledge, including information about the citizenship or alien status of each household member reapplying for assistance.
- I understand and agree to provide all documents to complete my telephone interview.
- I understand and agree that the County Department of Job and Family Services (CDJFS) may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.
- I understand that in some instances, I may be asked to give consent to the CDJFS to make whatever contacts are necessary to determine eligibility.
- I received a copy of, and I have read, my rights and responsibilities (JFS 07501), and I understand them. I agree to fulfill my responsibilities as described. I understand that my reapplication will be considered without regard to race, color, national origin, sex, age, disability, religion or political beliefs.

Phone Number	Alternate Phone Number	E-Mail Address	
Signature of Person Completing Form or Authorized Representative		If Auth. Representative, Relationship to Applicant	Date

Step 4: Return this form to us. We must receive it by the deadline listed above.

OFFICE USE ONLY – Do not use for medical assistance

Date Received	Caseworker/District Number	Case Worker Contact Number

Ohio Department of Medicaid

HEALTHCHEK AND PREGNANCY RELATED SERVICES INFORMATION SHEET

HEALTHCHEK – CHECK IT OUT!

Did you know Ohio's Medicaid program includes **Healthchek** services for children up to 21 years of age? (These services are also called EPSDT sometimes.) **Healthchek** services help children stay healthy and reduce the changes of sickness by treating health problems early. All **Healthchek** services are free. You can get help and information by contacting your county Healthchek Coordinator or your managed care plan and by going to http://medicaid.ohio.gov/FOROHIOANS/Programs/Healthchek.aspx

Screening Services

Doctors want children to have well-child check-ups (screenings) while they are growing up so that health problems can be found early. Check-ups covered by **Healthchek** include:

- Physical check-ups
- Vision checks
- Dental checks
- Hearing checks
- Nutrition screenings
- Mental health screenings
- Developmental screenings
- Immunizations, if needed

Mothers should have at least one prenatal exam and children should have exams at birth, 3 to 5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one exam per year. All children should have tests for lead poisoning.

Treatment Services

If the doctor finds a problem during a check-up, the doctor may provide the treatment or may refer you to another doctor. **Healthchek** covers treatment services. Some services may need prior approval. If your child is not in a managed care plan and needs prior approval for a service, your doctor will need to request it from Ohio Medicaid. If you child is in a managed care plan, your doctor will request prior approval from the plan. If you disagree with the decision made by Ohio Medicaid or your child's managed care plan, you can ask for a hearing. Check with your Healthchek Coordinator for more information.

Support Services

The names, addresses and phone numbers of Healthchek Coordinators for all counties can be found at http://medicaid.ohio.gov/Portals/0/For%20Ohioans/Programs/countycoordinators.pdf or by calling your County Department of Job and Family Services. If you need to find a doctor, dentist or other health care provider, your county Healthchek Coordinator can give you a list. Your Healthchek Coordinator can also help you make doctor's appointments and help you get transportation to the doctor. If your child is in a managed care plan, the plan can also help make doctor's appointments and may provide transportation to the doctor. The plan can also give you a list of doctors in their plan. You can go to the plan's website for more information.

You can ask your Healthchek Coordinator to make referrals for you to Head Start, the Women, Infants, and Children (WIC) program, Help Me Grow, and the Bureau for Children with Medical Handicaps. Your Healthchek Coordinator can give you names of other agencies that can help you get clothing, housing, food, and other services. You may also submit questions using an online form found at http://medicaid.ohio.gov/CONTACT.aspx.

Ohio Department of Medicaid

HEALTHCHEK AND PREGNANCY RELATED SERVICES INFORMATION SHEET

Please fill out the following information in order to help us provide **Healthchek** services to you and/or your child. If you do not understand some or all of this form, please contact your county Healthchek Coordinator. **Please return this Information Sheet** to the Healthchek Coordinator at your County Department of Job and Family Services, or **mail it back in the envelope included with this packet. Please keep the cover letter for your records so you can refer to it again.**

Your Information

First Name		Last Name		
Case Number		Street Address, Apt. No.		
City	State	Zip Code	County	Date of Birth
Email		Telephone Number		

Your Child's Information

Child's Name	SSN or Medicaid Billing No.
Child's Name	SSN or Medicaid Billing No.
Child's Name	SSN or Medicaid Billing No.
Child's Name	SSN or Medicaid Billing No.

Is your child enrolled in a Medicaid managed care plan?

☐ Yes. Plan _____

☐ No. Before enrolling in a plan, make sure your (or your child's) doctors or clinics are on the plan's list of providers.

Healthchek Screening Services

Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone on Medicaid and under 21 years of age. It also covers complete medical, vision, dental, hearing, nutritional, psychological, and mental health exams. These exams are important to make sure that your child is healthy and is developing physically and mentally. Mothers should have at least one prenatal exam and children should have exams at birth, 3 to 5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have a least one **Healthchek** exam per year until 21 years of age. **Please check all service you or your child would like to receive.**

☐ A comprehensive medical exam
☐ A vision (eye) exam
☐ A hearing exam
☐ A mental health exam
☐ A dental (tooth) exam: _____
☐ A specialist exam: _____

Healthchek Treatment Services and Transportation to Health Care Appointments

Healthchek covers tests and treatment services to treat problems or conditions found by an exam. Some tests and treatment services require pre-approval. If you need pre-approval, your provider must ask Ohio Medicaid or your managed care plan.

Your Healthchek Coordinator can help you make medical, dental and other appointments and provide free transportation to those appointments, if needed. If you or your child is enrolled in a managed care plan, the plan can also help with appointments and provide transportation. If can also give you a list of doctors in your plan. In order to make sure that you and your child get what you both need, **please check everything you or your child would like to receive.**

☐ A list of doctors
☐ A list of dentists
☐ A list of other healthcare professionals
☐ Other help getting treatment
☐ Transportation to medical or dental appointments
☐ Referrals to Help Me Grow
☐ Referrals to the Bureau for Children with Medical Handicaps
☐ Other information about where to get treatment

Do you or your child have any problems that need attention or treatment (for example, a medical problem, a mental health problem, a child who is not developing normally, etc.)? If so, please tell us more about this.

Other information about your child's history

My child has been tested for lead poisoning	☐ Yes	☐ No	☐ Don't know
My child's immunizations (shots) are up-to-date	☐ Yes	☐ No	☐ Don't know
My child has had developmental exams	☐ Yes	☐ No	☐ Don't know

Support Services

Your Healthchek Coordinator can also give you information about available services like the Women, Infants, and Children (WIC) program and other services offered through your local health department and other local agencies.

Would you like more information about other services? Please check all that apply.

☐ Women, Infants and Children (WIC) ☐ Food Assistance
☐ Heating Assistance ☐ Head Start
☐ Other: _____

Is anyone in your family (including yourself) pregnant? ☐ Yes ☐ No

If YES, give the name(s) of the pregnant woman. _____

If known, give the date(s) the baby is due: Month _____ Year _____

Is the pregnant woman now going to a doctor or clinic for the pregnancy? ☐ Yes ☐ No

If YES, give the name of the doctor or clinic. _____

Do you need other social services? ☐ Yes, Specify: _____ ☐ No

Are you currently enrolled in a managed care plan or HMO? ☐ Yes ☐ No

If YES, specify name of plan or HMO. _____

(Note: Before you enroll in an HMO, be sure that your doctor or clinic is on the HMO's list. If you enroll in an HMO in the future, be sure to tell the HMO staff about the services you would like to get.)

Acknowledgement

I have been given information about Healthchek. I understand that I can ask for Healthchek services or assistance at any time. I understand that I will be asked to sign a separate release form if my medical information needs to be shared with others.

Signature		Date
Caseworker Signature	Date	Phone
Caseworker Email		

Caseworker: Please forward this information to the appropriate Medicaid managed care plan.

Supplemental Tax Questions for MAGI Medicaid Applications

List ALL individuals living in the household	Primary Applicant				
How is this person related to the Primary Applicant?	Self				
How will this person file federal income tax NEXT YEAR?	☐ Not Filing ☐ Single ☐ Married Jointly ☐ Married Separately ☐ ** Claimed as a Tax Dependent by Another Person	☐ Not Filing ☐ Single ☐ Married Jointly ☐ Married Separately ☐ ** Claimed as a Tax Dependent by Another Person	☐ Not Filing ☐ Single ☐ Married Jointly ☐ Married Separately ☐ ** Claimed as a Tax Dependent by Another Person	☐ Not Filing ☐ Single ☐ Married Jointly ☐ Married Separately ☐ ** Claimed as a Tax Dependent by Another Person	☐ Not Filing ☐ Single ☐ Married Jointly ☐ Married Separately ☐ ** Claimed as a Tax Dependent by Another Person
** If this person is claimed as a tax dependent by another person, list the name of the person filing taxes and how he/she is related to this person.	Name of Tax Filer: Relationship:	Name of Tax Filer: Relationship:	Name of Tax Filer: Relationship:	Name of Tax Filer: Relationship:	Name of Tax Filer: Relationship:
If this person files taxes and claims dependents, list the names of the tax dependents that this person claims.	Tax Dependents:	Tax Dependents:	Tax Dependents:	Tax Dependents:	Tax Dependents:

We need the information above to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to provide verification.

By signing this form, you are granting Job & Family Services permission to verify information for all household members using information in our electronic databases, and you are stating that you have the authority to grant permission for electronic verification for all household members.

Signature	Date

VII. ADAAA and Section 504 of the Rehabilitation Act

The ADAAA and Section 504 of the Rehabilitation Act apply to all individuals who have a physical or mental impairment which substantially limits a major life activity. This is a very broad definition that covers many individuals, including many who do not otherwise receive and/or do not qualify for disability benefits, such as Supplemental Security Income (SSI) or Social Security Disability (SSD) benefits.

Examples of physical impairments: Blindness, low vision, deafness, hearing limitations, arthritis, cerebral palsy, HIV, AIDS, traumatic brain injury, asthma, irritable bowel syndrome, quadriplegia, cancer, diabetes, multiple sclerosis, anatomical loss, alcoholism, and past illegal use of drugs. This list is meant to provide examples of physical impairments, but is not intended to be a complete list of physical impairments subject to this policy.

Examples of mental impairments: Clinical depression, bi-polar disorder (manic depression), anxiety disorder, post-traumatic stress disorder, learning disabilities (e.g., dyslexia), attention deficit disorder, mental retardation. This list is meant to provide examples of mental impairments, but is not intended to be a complete list of mental impairments subject to this policy.

Examples of major life activities: Engaging in manual tasks, walking, standing, lifting, bending, performing manual tasks, speaking, hearing, seeing, breathing, eating, sleeping, taking care of oneself, learning, reading, concentrating, thinking, and working. Major life activities also include major bodily functions such as bladder, bowel, digestive, immune system, cell growth, brain, neurological, circulatory, endocrine, and reproductive functions.

The ADAAA and Section 504 protect individuals inquiring, applying, or receiving benefits and services that are provided by our CDJFS. For example, an individual with a disability who wants information about CDJFS programs who has not yet applied for benefits has a right to access that information and a right to reasonable accommodations that make it possible for him or her to do so.

We will not discriminate against family members and others who accompany someone applying for benefits.

The individual must meet essential program eligibility requirements: If an individual does not meet essential program eligibility requirements, it is not discriminatory for us to exclude him or her from a program. "Essential program eligibility requirements" include, but are not limited to: residency, income, and citizenship.

Past history of a disability: The ADAAA and 504 also protect individuals who previously had a disability from discrimination because of that history.

Regarded as having a disability: The ADAAA and 504 protects individuals who are not actually disabled from discrimination that results from a perception by our staff that they are disabled. For example, the CDJFS cannot treat someone unfavorably based upon a belief that a minor condition is much more limiting than it is.

Voter Registration and Information Update Form

Please read instructions carefully. Please type or print clearly with blue or black ink.
For further information, you may consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call 1-877-767-6446.

Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be received or postmarked by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Numbers 1 and 2 below are required by law. You must answer **both** of the questions for your registration to be processed.

Registering in Person
If you have a current valid Ohio driver's license, you must provide that number on line 10. If you do not have an Ohio driver's license, you must provide the last four digits of your Social Security number on line 10. If you have neither, please write "None."

Registering by Mail
If you register by mail and do not provide either an Ohio driver's license number or the last four digits of your Social Security number, you must enclose with your application a copy of one of the following forms of identification:

Current and valid photo identification, a military identification, or a current (within the last 12 months) utility bill, bank statement, paycheck, government check or government document (other than a notice of voter registration mailed by a board of elections) that shows your name and current address.

Residency Requirements
Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

Your Signature
In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

Please see information on back of this form to learn how to obtain an absentee ballot.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

FOLD HERE

I am: ☐ **Registering as an Ohio voter** ☐ **Updating my address** ☐ **Updating my name**

1. Are you a U.S. citizen? ☐ **Yes** ☐ **No**
2. Will you be at least 18 years of age on or before the next general election? ☐ **Yes** ☐ **No**
If you answered NO to either of the questions, do not complete this form.

3. Last Name | First Name | Middle Name or Initial | Jr., II, etc.

4. House Number and Street (Enter new address if changed) | Apt. or Lot # | 5. City or Post Office | 6. ZIP Code

7. Additional Mailing Address or P.O. Box (if necessary) | 8. County (where you live)

9. Birthdate (MO-DAY-YR) (required) | 10. Ohio Driver's License No. OR Last Four Digits of Social Security no. (one form of ID required to be listed or provided) | 11. Phone No. (voluntary)

12. **PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION** - Previous House Number and Street

Previous City or Post Office | County | State

13. **CHANGE OF NAME ONLY** Former Legal Name | Former Signature

14.
I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.

Your Signature ↓ Date_____/_____/_____ MO DAY YR

FOR BOARD USE ONLY
SEC4010 (Rev. 6/14)

City, Village, Twp.

Ward

Precinct

School Dist.

Cong. Dist.

Senate Dist.

House Dist.

To ensure your information is updated, please do the following:

1. Print this form.
2. Complete all required fields.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections. For your county board's address please visit www.OhioSecretaryofState.gov/boards.htm.

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (767-6446).

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: www.OhioSecretaryofState.gov or by calling 1-877-767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring identification to the polls in order to verify identity. Identification may include current and valid photo identification, a military identification, or a copy of a current (within the last 12 months) utility bill, bank statement, government check, paycheck, or other government document, other than a notice of an election or a voter registration notification sent by a board of elections, that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at:www.OhioSecretaryofState.gov or call 1-877-767-6446.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

Ohio Department of Job and Family Services

VOTER REGISTRATION
NOTICE OF RIGHTS AND DECLINATION

County Department of Job and Family Services

Name	Date

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ YES, I want to register to vote.
☐ NO, I do not want to register to vote.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Signature

(This portion to be retained by agency)

- -

(This portion to be given to applicant/recipient)

Date

If you have not received any verification of your voter registration from the county board of elections in which you reside within 21 days from the date you registered, you may inquire about the status of your registration by contacting your county board of elections.

If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the prosecuting attorney of your county or with the Secretary of State:

Ohio Secretary of State
180 E. Broad Street
Columbus, OH 43215
(614) 466-2585
Toll Free: (877) 868-3874

Address of County Prosecutor
City, State and Zip Code of County Prosecutor
Phone Number of County Prosecutor