Ohio

Medicaid Renewal Form

Notice Date:
Respond By:
Case Number:

Questions? Ask your worker.

TDD - For the Hearing Impaired: 7-1-1
Phone: (844)640-6446
Phone Hours: (M–F) 7AM – 8PM (Sat) 8AM – 5PM (Sun) Closed

It is time to renew your Medicaid coverage.

If you receive Medicaid, Medicare Premium Assistance, Long Term Care, or Waiver services, you must respond to this notice to renew those services.

If you are unable to read English and need this form translated into your preferred language, contact your case worker. Please call the number listed above for assistance.

Si no puede leer inglés y necesita este formulario traducido a su idioma preferido, póngase en contacto con el trabajador a cargo de su caso. Por favor llame al número mencionado arriba para asistencia.

Haddii aanad awood u lahayn in aad akhrido oo aad u baahantahay in loo turjumo foomkan luqadda aad doorbidayso, la xidhiidh shaqaalaha kiiskaaga. Fadlan wac lambarka kor ku qoran wixii caawimo ah.

You Can Renew Your Medicaid in any one of these ways	- **Online:** If you have an online account, go to ssp.benefits.ohio.gov, logon and click on Renew My Benefits - **By mail:** Complete this form and mail it to your local County Department of Job and Family Services (CDJFS)*. - **In person:** Visit your local CDJFS* - **By phone:** (844)640-6446
*Find the address to your local office at: jfs.ohio.gov/county/county_directory.pdf	
How to complete this renewal form	1. Answer all of the questions on the form. If you do not have all of the information asked for, still sign and submit this form. 2. Add any missing information. If any information has changed, cross out the old information and write in the new information. If you need more space to provide additional information about yourself or someone in your household or on your tax return, print copies of the page or write the information on a separate sheet of paper and attach it to this form. 3. Sign the form on page 9. **4. Respond to this form by . If you do not respond to this form by the deadline, you will lose your Medicaid coverage.**
What we need	Information about each person living in your household or listed on your tax return including employer and income information, for example: information from pay stubs, W-2 forms, or wage and tax statements ***AND*** policy numbers for any current health insurance.
What happens next?	We will process your renewal. If you do not hear from us in 1-2 weeks, call (844) 640-6446

If you, someone in your household or on your tax return is not already on Medicaid and would like to apply for health insurance, a new application must be completed. You can apply online at healthcare.gov or benefits.ohio.gov or by calling (844)640-6446 or in person at your local CDJFS.

1 Your contact information

	Name *(first, middle, last & suffix)*		
Home Address:	**Home** Address		Apartment #
	City (*home*)	State	Zip code
Mailing Address:	**Mailing** Address		Apartment #
	City (*mailing*)	State	Zip code
Phone:	Best phone number to reach you: ☐Home ☐Cell ☐Work Number:		
	Other phone number, if you have one: ☐Home ☐Cell ☐Work Number:		

Email Address: ☐ I want to receive information by email

Voter Registration Application Attached - Help completing this form is available if you need it.
If you are not registered to vote where you live now, would you like to apply to register to vote today? If you do not check either box, you will be considered to have decided not to register to vote at this time.

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

Do you want to apply for any of the following programs?

☐ Healthy Start & Healthy Families (Medicaid)
☐ Nutritional Program for Women, Infants & Children (WIC)
☐ Child & Family Health Services (CFHS)
☐ Bureau for Children with Medical Handicaps (BCMH)
☐ Help Me Grow

2 We need information about who files tax returns.

You must renew even if you do not file a tax return.

Will anyone in the household file a **federal tax return *next year*** to report income earned ***this year***?

☐ ***If yes,*** answer all of the questions below. ☐ ***If no,*** answer the question marked with a star * below

Person 1: Name (*first, middle, last & suffix*)

If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

Person 2: Name (*first, middle, last & suffix*)

This is for a second tax filer in the household
If this person is filling a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

* If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents. Answer only if different than what you reported above or if you did not fill in any information above.

Name of tax filer: _____

Name of dependents: _____

_____

3 We need information about these people

Person 1:

☐ Please provide the person's date of birth: ___ / ___ / _____

☐ Please provide the person's Social Security Number: ____ - ____ - _____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

☐ Please provide the following information:

Alien ID: _____ Document Type: _____

Person 2:

Relationship to Person 1:

☐ Please provide the person's date of birth: ___ / ___ / _____

☐ Please provide the person's Social Security Number: ____ - ____ - _____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

☐ Please provide the following information:

Alien ID: _____ Document Type: _____

Person 3:

Relationship to Person 1:

☐ Please provide the person's date of birth: ___ / ___ / _____

☐ Please provide the person's Social Security Number: ____ - ____ - _____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

☐ Please provide the following information:

Alien ID: _____ Document Type: _____

Person 4:

Relationship to Person 1:

☐ Please provide the person's date of birth: ___ / ___ / _____

☐ Please provide the person's Social Security Number: ____ - ____ - _____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

☐ Please provide the following information:

Alien ID: _____ Document Type: _____

Person 5:

Relationship to Person 1:

☐ Please provide the person's date of birth: ___ / ___ / _____

☐ Please provide the person's Social Security Number: ____ - ____ - _____

☐ Check here if this person is no longer living in the household and is not claimed on your tax return

☐ Please provide the following information:

Alien ID: _____ Document Type: _____

4 We need more information about people not listed in Section 3 *(page 3)*

Tell us about anybody else in your household or on your tax return that is not listed in Section 3.

Name of other person: (*first, middle, last & suffix*):

☐ Please provide the person's Social Security Number.

____ - ____ - ______

This person may choose not to give the Social Security Number, but it helps us to have it.

☐ Check here if this person **has** Medicaid.

☐ Check here if this person is no longer living in the household.

Date of birth (month/ day/ year):

This person is: ☐ Male ☐ Female

How is this person related to you?

Name of other person: (*first, middle, last & suffix*):

☐ Please provide the person's Social Security Number.

____ - ____ - ______

This person may choose not to give the Social Security Number, but it helps us to have it.

☐ Check here if this person **has** Medicaid.

☐ Check here if this person is no longer living in the household.

Date of birth (month/ day/ year):

This person is: ☐ Male ☐ Female

How is this person related to you?

Name of other person: (*first, middle, last & suffix*):

☐ Please provide the person's Social Security Number.

____ - ____ - ______

This person may choose not to give the Social Security Number, but it helps us to have it.

☐ Check here if this person **has** Medicaid.

☐ Check here if this person is no longer living in the household.

Date of birth (month/ day/ year):

This person is: ☐ Male ☐ Female

How is this person related to you?

Name of other person: (*first, middle, last & suffix*):

☐ Please provide the person's Social Security Number.

____ - ____ - ______

This person may choose not to give the Social Security Number, but it helps us to have it.

☐ Check here if this person **has** Medicaid.

☐ Check here if this person is no longer living in the household.

Date of birth (month/ day/ year):

This person is: ☐ Male ☐ Female

How is this person related to you?

Name of other person: (*first, middle, last & suffix*):

☐ Please provide the person's Social Security Number.

____ - ____ - ______

This person may choose not to give the Social Security Number, but it helps us to have it.

☐ Check here if this person **has** Medicaid.

☐ Check here if this person is no longer living in the household.

Date of birth (month/ day/ year):

This person is: ☐ Male ☐ Female

How is this person related to you?

5 Tell us about *other* health insurance coverage people have

Include anyone in Section 3 and 4.

Name of insurance company: | Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance ______________

List everyone who is on this policy: ☐ Check here if this is a limited benefit policy

Name of insurance company: | Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance ______________

List everyone who is on this policy: ☐ Check here if this is a limited benefit policy

☐ Check here if anyone on this form is offered health insurance through a job, even if they are not enrolled.

Tell us who. Name: ______________________________

6 Tell us more about the people listed on this form

Is anyone pregnant?

Name (*first, middle, last & suffix*):	How many babies are expected?	Due Date:
Name (*first, middle, last & suffix*):	How many babies are expected?	Due Date:

Is anyone between the ages of 18 and 26 and was in foster care and in receipt of Ohio Medicaid on his or her 18th birthday?

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

Is anyone blind or disabled?

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

Does anyone have a medical, mental health, or substance use condition that limits his or her ability to work, go to school, or take care of daily activities (like bathing or dressing)?

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

Does anyone live in a long term care facility, group home, or nursing home, or regularly gets medical care, personal care, or health services at home or in another community setting (like adult day care)?

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

Is anyone between the ages of 18 and 22 and also a full-time student?

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

7 Tell us about work

Fill in the information below for everyone in your household or on your tax return who has income from a job (**not** self-employed). If someone has more than one job, tell us about **all jobs.** You can tell us about **self-employment** on the next page.

Job 1: Name of the person who is working (*first, middle, last & suffix*):

Employer name:	**Employer** phone number:
Employer address:	
How often are wages or tips paid? ☐ Hourly ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
How much does this person get paid (before taxes)? **$**	Average hours worked each week:

Job 2: Name of the person who is working (*first, middle, last & suffix*):

Employer name:	**Employer** phone number:
Employer address:	
How often are wages or tips paid? ☐ Hourly ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
How much does this person get paid (before taxes)? **$**	Average hours worked each week:

Job 3: Name of the person who is working (*first, middle, last & suffix*):

Employer name:	**Employer** phone number:
Employer address:	
How often are wages or tips paid? ☐ Hourly ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
How much does this person get paid (before taxes)? **$**	Average hours worked each week:

Job 4: Name of the person who is working (*first, middle, last & suffix*):

Employer name:	**Employer** phone number:
Employer address:	
How often are wages or tips paid? ☐ Hourly ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
How much does this person get paid (before taxes)? **$**	Average hours worked each week:

Job 5: Name of the person who is working (*first, middle, last & suffix*):

Employer name:	**Employer** phone number:
Employer address:	
How often are wages or tips paid? ☐ Hourly ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
How much does this person get paid (before taxes)? **$**	Average hours worked each week:

Section 7 continued on next page **> > >**

7 Tell us about work *(continued)*

List anyone in your household or on your tax return who has changed jobs or has worked fewer hours in the past four months.

1. Name (*first, middle, last & suffix)*:

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

2. Name (*first, middle, last & suffix)*:

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

List anyone in your household or on your tax return who is **self-employed**

Subtract the expenses below from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to self-employed SEP, SIMPLE, or qualified retirement plan

1. Name (*first, middle, last & suffix)*:

Type of work:

How much net income will this person get from self-employment this month? Amount: **$**

2. Name (*first, middle, last & suffix)*:

Type of work:

How much net income will this person get from self-employment this month? Amount: **$**

8 Tell us about other income

List the names of anyone whose income **changes** from month to month.

1. Name (*first, middle, last & suffix)*:

What do you expect his or her income to be **this year**? Amount: **$** ☐ I do not know what their income will be.

2. Name (*first, middle, last & suffix)*:

What do you expect his or her income to be **this year**? Amount: **$** ☐ I do not know what their income will be.

3. Name (*first, middle, last & suffix)*:

What do you expect his or her income to be **this year**? Amount: **$** ☐ I do not know what their income will be.

Unemployment Compensation	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Social Security	**How much?**	**How often?**

Section 8 continued on next page **> > >**

8 Tell us about other income *(continued)*

Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Pensions	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Retirement accounts	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Alimony received	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Farming or fishing (*profit after business expenses)*	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Rental income or royalties (*profit after business expenses)*	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Other income Type:	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Other income Type:	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other

If anyone in your household has **tax deductions**, tell us what kind.

Alimony paid to someone else	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Student loan interest paid	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other
Other Deductions Type:	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other

9 Read and sign this application

Renewal of coverage in future years

Read the following statement and check **one** box: To make it easier to electronically verify my income at renewal time, I give the Ohio Department of Medicaid permission to use computer data information from my federal tax returns, provided by the IRS, for the number of years I checked below. I understand that the Ohio Department of Medicaid will send me the information it has verified and I will have a chance to correct and update this information. I can also change my mind, at any time, and not allow the Ohio Department of Medicaid to check this information.

Yes, I give permission to use computer data information from my federal tax returns, provided by the IRS, to electronically verify my income for (check one box):

☐ 5 years (the longest time) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, I do not give permission to use my tax returns.

Your rights and responsibilities

- I am signing this renewal form under penalty of perjury which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell the Ohio Department of Medicaid if anything changes (and is different from) what I wrote on this form. I can call (844) 640-6446 to report any changes within 10 days. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that the Ohio Department of Medicaid will get information about my financial resources from banks, credit unions, or other financial institutions in order to determine my eligibility for medical assistance. Authorization to get this information remains in effect until:
  - My application for medical assistance is denied; or
  - My eligibility for medical assistance ends; or
  - I inform the Ohio Department of Medicaid in writing that I wish to end my authorization.
- If I refuse to authorize the Ohio Department of Medicaid to get information about me from financial institutions, or I decide to end my authorization, I understand that my medical assistance may be denied or discontinued.

If anyone on this application is eligible for Medicaid

- I am giving the Ohio Department of Medicaid our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving the Ohio Department of Medicaid our rights to pursue and get medical support from an ex-spouse or parent.
- Does any child on this renewal form have a parent living outside of the home? ☐ Yes ☐ No
  - If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I understand that when I send in this form, it means I have permission from everyone whose information is on the form to submit their information to Ohio Department of Medicaid and receive any communications about their eligibility and enrollment.
- I authorize any person who furnishes health care or medical supplies or services to give the Ohio Department of Medicaid, the Ohio Department of Job & Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Medicaid program, WIC, and other medical assistance programs. I also authorize the previously mentioned departments to exchange any information I have provided on this form, to enable the departments to determine my eligibility.
- I understand that if I do not qualify for Medicaid, the Ohio Department of Medicaid may send my information to another program so they can see if I qualify.
- The Ohio Department of Medicaid will check my answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, the Ohio Department of Medicaid may ask me to send more information.
- I understand that, after my death, Ohio Department of Medicaid can file a claim against my estate to recover money that the state paid for coverage provided to me. This process must happen if I am in a medical institution and not expected to return home, or if I am 55 years of age or older and the state pays for my nursing facility services, home and community based services, or related hospital and prescription drug services. The amount recovered by the Ohio Department of Medicaid will not be more than the amount Medicaid paid for my care.
- I understand that the Ohio Department of Medicaid is authorized to collect information on this form, and other supporting information including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (Public Law 111-152) and the Social Security Act.

My right to appeal

If I think that the Ohio Department of Medicaid or the Health Insurance Marketplace has made a mistake I can appeal its decision. To appeal means to tell someone at the Ohio Department of Medicaid or the Health Insurance Marketplace that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Ohio Department of Medicaid at (844) 640-6446. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign and date below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment A on page 10. The last page is a Voter Registration From and is not part of your Medicaid renewal. If you wish to register to vote, fill that form out and return it separately to your county board of elections.

☐ Check here if you are an authorized representative. Sign below and fill out Attachment A on page 10.

Signature of household contact or authorized representative:	Date:

Attachment A Assistance with completing this renewal form

You can give a trusted person permission to talk about this renewal form with us, see your information, and act for you on matters related to this form, including getting information about your renewal and signing your form on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local County Department of Job and Family Services. If you're a legally appointed representative for someone on this application, submit proof with this form.

If you have an authorized representative now, please answer these questions.

We show that you chose this person as your authorized representative:

Do you still want this person to be your authorized representative

☐ Yes ☐ No

If yes, has any of his or her information changes?

☐ Yes ☐ No

If your authorized representative's information has **changed**, or if you would like a **different** authorized representative, please write the new information below:

Name of authorized representative:

Address: Apartment # City State Zip code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: Date:

If you do not have an authorized representative and want one, please answer these questions.

☐ Check here if you are an authorized representative. Answer the questions below.

Name of authorized representative:

Address: Apartment # City State Zip code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: Date:

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 (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."

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

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, government check, paycheck, or government document (other than a notice of voter registration mailed by a board of elections) that shows the voter's 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.

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

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 (if necessary)	8. County (where you live)

9. Birthdate (MM/DD/YYYY) (required)	10. Ohio Driver's License number OR Last Four Digits of Social Security number (one form of ID required to be listed or provided)	11. Phone Number (voluntary)

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

Previous City or Post Office	Previous County	Previous 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** (MM/DD/YYYY) _____

FOR BOARD USE ONLY SEC4010 (rev. 4/15)
City, Village, Twp.
Ward
Precinct
School Dist.
Cong. Dist.
Senate Dist.
House Dist.

TO ENSURE YOUR INFORMATION IS RECEIVED, PLEASE DO THE FOLLOWING:

1. Print this form.
2. Make sure all required fields are complete.
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 (877-767-6446).

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 (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 voter registration mailed 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 (877) 767-6446.

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

To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to: oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling County Shared Services at the toll-free phone number 1-844-640-6446; individuals with a hearing impairment may call TDD 7-1-1.

Spanish:
Para ayudarle a entender este aviso, se ofrecen asistencia con el idioma, servicios de interpretación y ayudas y servicios auxiliares a solicitud sin costo alguno para usted. Los servicios disponibles incluyen, entre otros, traducción oral, traducción por escrito y ayudas auxiliares. Para solicitar estos servicios o ayudas auxiliares, llame sin costo a Servicios Compartidos del Condado al teléfono 1-844-640-6446; las personas con discapacidad auditiva pueden llamar a TDD 7-1-1.

Arabic
لمساعدتك على فهم هذا الإخطار، تتوفر المساعدة اللغوية وخدمات الترجمة الفورية والأدوات والخدمات المساعدة عند الطلب مجانًا وبدون أي تكلفة.
تشمل الخدمات المتاحة، على سبيل المثال لا الحصر: الترجمة الشفهية والترجمة التحريرية والأدوات المساعدة.
يمكنك طلب هذه الخدمات و/أو الأدوات المساعدة عن طريق الاتصال بخدمات المقاطعة المشتركة على رقم الهاتف المجاني 1-844-640-6446؛ يمكن للأفراد الذين يعانون من ضعف السمع الاتصال برقم الهاتف النصي 7-1-1.

Somali:
Si lagaaga caawiyo inaad fahanto ogeysiiskan, caawin luqadeed, adeegyada turjumaanka, iyo qalabka iyo adeegyada naafada ayaa la heli karaa marka la codsado iyadoo aan kharash kaa bixin. Adeegyada la heli karo waxaa ka mid ah, laakiine aan ku xaddidnayn: Tarjumaadda afka ah, turjumaad qoraalka ah, iyo qalabka naafada. Waxaad ku codsan kartaa adeegyadaa iyo/ama qalabka naafada adigoo ka wacaya Adeegyada la wadaago ee degmada (County Shared Services) taleefanka lacah la'aanta ah ee lambarka 1-844-640-6446; Dadka maqalka ku dhiban waxay wici karaan TDD 7-1-1.

Russian:
Чтобы помочь вам понять это уведомление, по вашему запросу бесплатно предоставляется языковая помощь, услуги устного перевода, а также дополнительные средства и услуги. В число доступных услуг входят, в частности, устный перевод, письменный перевод и вспомогательные средства. Вы можете обратиться за этими услугами и/или вспомогательными средствами, позвонив в County Shared Services по бесплатному телефону 1-844-640-6446; лица с нарушением слуха могут позвонить по номеру TDD 7-1-1.

French:
Pour vous aider à comprendre cette communication, une assistance linguistique, des services de traduction et des aides/services auxiliaires sont disponibles gratuitement sur demande. Les services disponibles comprennent, entre autres : traduction orale, traduction écrite et aides-auxiliaires. Vous pouvez consulter ces services et/ou des aides-auxiliaires en appelant les Services Partagés des Comtés (County Shared Services) au numéro gratuit suivant : 1-844-640-6446 ; les personnes ayant une déficience auditive peuvent appeler TDD 7-1-1.

Vietnamese:
Để giúp quý vị hiểu được thông báo này, dịch vụ hỗ trợ ngôn ngữ, dịch vụ thông dịch và các dịch vụ và trợ giúp bổ sung được cung cấp miễn phí cho quý vị khi có yêu cầu. Các dịch vụ có sẵn bao gồm nhưng không giới hạn ở: phiên dịch miệng, biên dịch và trợ giúp bổ sung. Quý vị có thể yêu cầu các dịch vụ này và/hoặc trợ giúp bổ sung bằng cách gọi cho Dịch vụ Chia sẻ của Quận theo số điện thoại miễn cước 1-844-640-6446; người khiếm thính có thể gọi đến TDD 7-1-1.

Swahili:
Ili kukusaidia kuelewa notisi hii, usaidizi wa lugha, huduma za ukalimani, na vifaa vya kusikia na huduma za kusikia zinapatikana ukiomba bila gharama yoyote kwako. Huduma zinazopatikana zinajumuisha, lakini sio tu: tafsiri kwa usemi, tafsiri kwa maandishi, na vifaa vya kusikia. Unaweza kuomba huduma hizi na/au vifaa vya kusikia kwa kupiga simu kwa County Shared Services (Huduma Zinazoshirikiwa za Kaunti) kwa nambari ya simu ya bila malipo 1-844-640-6446; watu walio na ulemavu wa kusikia wanaweza kupiga simu kwa TDD 7-1-1.

Ukrainian:
Для того, щоб Ви могли зрозуміти це повідомлення, за Вашим запитом безкоштовно надається мовна підтримка, послуги усного перекладу, а також допоміжні засоби та послуги. Послуги, що надаються, охоплюють, серед іншого: усні та письмові переклади, а також допоміжні засоби. Ви можете отримати ці послуги та/або допоміжні засоби, зателефонувавши до Центру надання муніципальних послуг округу за безкоштовним телефоном 1-844-640-6446; особи з вадами слуху можуть зателефонувати за номером 7-1-1 за допомогою телекомунікаційного приладу для глухих.

Kinyarwanda (Burundi):
Kugira ngo tugufasha gusobanukirwa iri tangazo, ubwunganizi mu by'indimi, serivisi z'ubusemuzi n'ubufasha na serivisi by'ibanze btangwa iyo ubisabye kandi nta kiguzi. Serivisi zitangwa zikubiyemo, ariko ntizigarukira kuri: ubusemuzi mu magambo, ubusemuzi mu nyandiko, n'ubufasha bw'ibanze. Ushobora gusaba izi serivisi no/cyangwa ubufasha bw'ibanze uhamagara County Shared Services kuri terefone itishyurwa nomero 1-844-640-6446; abantu bafite ubumuga bwo kutumva bashobora guhamagara TDD 7-1-1.

Afghani
برای اینکه کمک تان کنیم تا این اطلاعیه را درک کنید، مساعدت زبان، خدمات ترجمه شفاهی و کمک‌ها و خدمات حمایوی حین درخواست بطور رایگان برای شما موجود است. خدمات موجود شامل این موارد می‌شود، ولی تنها محدود به این موارد نمی باشد: ترجمه شفاهی، ترجمه کتبی و کمک‌های حمایوی. شما میتوانید این خدمات و/یا کمک‌های حمایوی را با زنگ زدن به County Shared Services با شماره رایگان 1-844-640-6446 درخواست کنید؛ افرادی که در بخش شنوایی مشکل دارند میتوانند به شماره TDD 7-1-1 زنگ بزنند.