

NOTICE OF APPROVAL OF YOUR APPLICATION FOR ASSISTANCE ODHS 4074 (Rev. 2/92)

Name
Street Address
City, State, and Zip Code

Assistance Group Name Medicaid	
Assistance Group Number	
County	Mailing Date

Your application for _____ dated _____ has been approved. The boxes which apply to your case have been checked to inform you of your benefits and the effective date.

Applicants for Public Assistance

- You have been found eligible beginning _____.
- You may only receive General Assistance for 6 months in any 12 month period.
- You have been found eligible for financial assistance in the amount of \$_____ per month.
- Your first check will contain a prorated payment of \$_____ for the month(s) of _____.
- You have been found eligible for program-related medical coverage beginning _____.
- You have been found eligible for Emergency Assistance (EA) as follows: _____

Applicants for Medicaid

- You have been found eligible for Medicaid with coverage beginning _____.
- You have been found eligible for retroactive Medicaid assistance for the months of _____, _____, and _____.
- Your income is \$_____ over the Medicaid income level. However, you have been found eligible for a program called Medicaid "spenddown". You must incur (run up) \$_____ in medical costs, which are not subject to payment by a third party, each month before your Medicaid card can be released to you. After you submit verification to your caseworker that you have incurred (whether paid or not paid) your monthly Medicaid "spenddown" amount, your monthly Medicaid card will be immediately issued to you. The effective date of Medicaid coverage will be the day on which you reach your "spenddown" level.
- You have been found eligible for nursing home vendor payments beginning _____. You must pay \$_____ to the nursing home each month for your care.
- You have been found eligible for home and community based services beginning _____. You must pay \$_____ (client liability) for your home and community based services each month.

Applicants for Social Services

- You have been found eligible for the following services: _____
- Your partial payment fee for _____ is \$_____ per _____ effective _____.

Other _____

The reasons for this action are _____

The rules which require this action are _____

Caseworker	District/ID Ohio Department Of MR/DD	Telephone Number (614)728-9508
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Your budget to determine eligibility has been computed as follows:

Please see page two of this form for important information regarding your right to state hearing.

Your Right to a State Hearing

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After discussing the reasons for the action with your caseworker, it is possible that we will change our decision or that you will agree with the action.

If you do not agree with this action, you have a right to a state hearing. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend or be represented at the hearing to present our reasons. A hearing officer from the Ohio Department of Human Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date of this notice. You do not need to return this form if you agree with the action.

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.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free at 1-(800)-589-5888, for the local number.

If you want a state hearing, check the appropriate boxes below, sign and date this form and send it to the Ohio Department of Human Services, State Hearings, 30 East Broad Street, 32nd floor, Columbus, Ohio 43266-0423.

- I want a county conference and a state hearing on this action.
- I want a state hearing only.

I want a hearing

Signature	Date	Telephone Number
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