Reset Form

Ohio Department of Job and Family Services

MEDICAID BUY-IN FOR WORKERS WITH DISABILITIES (MBIWD) ADDENDUM

MBIWD is an Ohio Medicaid program that provides health care coverage to working Ohioans with disabilities. MBIWD was created to enable Ohioans with disabilities to work and keep their health care coverage, in accordance with rule 5101:1-41-30.

Do I qualify?

1. You must be a U.S. citizen or qualified alien.
2. You must be a resident of Ohio.
3. You must be at least 16 years of age but less than 65 years of age.
4. You must be determined disabled by the Social Security Administration **or** by Ohio Medicaid. *You may be required to submit documentation of your disability.*
5. You must meet certain financial criteria.
6. You must be employed in paid, taxed work.
7. You must pay a premium (if applicable).

Premiums

Monthly premiums may be required for eligible applicants with annual gross income greater than 150% of the federal poverty level. Each enrollee will be sent a monthly statement with the monthly premium amount which must be paid by check or money order. The full amount of the premium must be received by the due date or it will be considered non-payment. Late payments will be applied to the most delinquent month. Enrollees who do not pay their premium for two consecutive months will be subject to termination and collections.

How do I apply?

1. Complete the *Cash, Food Stamp, and Medical Assistance* application (JFS 07200) and the enclosed MBIWD addendum (JFS 07211). **No face-to-face interview is required for MBIWD.** If you need help to answer the questions, call the Medicaid Consumer Hotline at 1-800-324-8680 or TTY 1-800-292-3572.
2. Attach proof of your citizenship, income, resources, and impairment-related work expenses.
3. Sign and return a copy of form JFS 07236 *Rights and Responsibilities* with your application.
4. Mail the application, MBIWD addendum and verifications to your local county department of job and family services. A caseworker will contact you if additional information is needed. They will determine if you are eligible for MBIWD, inform you of the decision and tell you if you have a premium.

Proof of Citizenship

Many documents satisfy proof of U.S. citizenship. Below is a partial list of acceptable documents. For a complete list of documents that satisfy the U.S. citizenship requirement, visit: http://www.cms.hhs.gov/smdl/downloads/SMD06012.pdf. In order to comply with federal law, caseworkers must see **original documents** and make photocopies to keep in the file. If the original document is unavailable, a copy certified by the originating agency will be accepted. *Citizenship* documents alone satisfy the U.S. Citizenship requirement. If you cannot obtain the documents from the *Citizenship* category, you must provide both a *Birth* **and** an *Identity* document to satisfy this requirement. **Individuals who are currently receiving Medicare, SSI or SSDI are exempt from verifying their citizenship. Citizenship only needs to be verified once.**

Citizenship documents:	**Birth documents:**	**Identity documents:**
• U.S. passport • Certificate of Naturalization • Certificate of U.S. Citizenship	• U.S. birth certificate • Certificate of birth abroad • U.S. National ID card • Native American Tribal document • Final adoption decree	• Driver's license or state ID • ID issued by a federal, state, or local government agency • U.S. military card or draft record • School ID card
You must have **one** of these documents	***OR* one** birth document ***AND* one** identity document to satisfy the requirement.	

Agency Use Only	Case Name	Case Number	Date Mailed / Picked Up	Date Returned to CDJFS	Unique ID

Medicaid Buy-In for Workers with Disabilities (MBIWD)

- This is not an application for cash assistance, regular Medicaid, food stamps, or waivers. If you wish to apply for other help, please call your local county department of job and family services.
- **If you have any questions, please call the Medicaid Consumer Hotline at 1-800-324-8680 or TTY 1-800-292-3572.**

Please print your answers to the following questions. You may use blank pages for additional space.

1. Are you disabled? ☐ Yes ☐ No
2. Have you been determined disabled by the Social Security Administration? ☐ Yes ☐ No
3. Are you working? ☐ Yes ☐ No

4. Applicant's name	5. Phone number	6. Social Security number	7. Social Security claim number

Non-citizens: Please provide proof of alien status such as an alien registration card or re-entry permit.

Alien registration number: _____

8. Do you need help paying any medical expenses from the past three months? (Retroactive health care coverage through MBIWD will not be explored prior to April 1, 2008.) ☐ Yes ☐ No

If you answered **Yes**, please complete JFS 07110, an application for retroactive coverage, and enclose or attach verification of your income, resources and medical expenses for each of the past three months.

9. During the next 12 months, do you expect any changes to your household? This includes the people you live with, the amount of money you and/or your spouse receive, a change in your resources, or other changes in circumstances you described on this application? ☐ Yes ☐ No

If you answered **Yes**, what changes do you expect?

10. **You must provide proof of income.** Include all household income from all sources such as Social Security, SSI, VA benefits, annuities, alimony, rental property income, employment or other type(s) of income like money from friends and family received on a regular basis.

11. List all of the resources that you own. If the resource is jointly owned, be sure to indicate the other owner(s) and the percentage you own.

Below are examples of resources you may own. (You will need to provide copies of the statements from the past 30 days.)

- Savings accounts
- Annuities
- Checking accounts
- Credit union
- Promissory notes
- Stocks/bonds
- Tax shelter accounts
- Certificate of deposits
- Automobiles
- 401Ks
- Trust funds
- Christmas clubs
- Other vehicles
- Money market funds
- Life insurance
- Land contracts
- IRAs
- Keough plans
- Revocable burial accounts
- Irrevocable burial accounts
- Other assets (describe)

Resource Type	Account #	Total Amount	Available?	Date Account Opened	Date Account Closed	Joint % With
			☐ Y ☐ N			___%
			☐ Y ☐ N			___%
			☐ Y ☐ N			___%
			☐ Y ☐ N			___%
			☐ Y ☐ N			___%
			☐ Y ☐ N			___%
			☐ Y ☐ N			___%
			☐ Y ☐ N			___%

12. Do you own all or part of any real estate in which you do **not** live? This includes houses, vacant land, farm land, rental property and business property. ☐ Yes ☐ No

If you answered **Yes**, please tell us about the property. **(Do not list the house where you live.)**

Address	Property Value $
Address	Property Value $

If applicable, you must provide proof of property value, loans, liens and encumbrances.

13. Does any member of your household have other health insurance coverage? **Please provide a copy of the front and back of the health insurance card.**

Primary Cardholder's Name	Name of Insurance Company / Plan	Policy #	Premium Amount & How Often Paid	Who is Covered?

14. If you receive a check from Social Security, is the Medicare Part B premium taken out of your check? ☐ Yes ☐ No

Date the deduction began _____

15. List impairment-related work expenses not paid by other sources (insurance, community organizations, etc.) and how often you pay for them (weekly, monthly, etc.). **You must provide verification.**

Impairment-related work expenses include but are not limited to:

- Attendant care services
- Durable medical equipment
- Interpreter (at workplace)
- Job coach
- Medical devices
- Measuring instruments
- Modified audio / visual equipment
- Pacemakers
- Physical therapy
- Prostheses
- Reading aids
- Respirators
- Special work tools
- Typing aids
- Wheelchairs
- Work animal & associated costs
- Workspace modifications

Type of Impairment-Related Work Expense	Amount of expense	How often paid?

16. If you are eligible for this program and must pay a premium, would you like the statement sent to your home address? ☐ Yes ☐ No

If you would like your statement to be mailed elsewhere, please provide that information below.

Name		Address	
City	State	Zip Code	Phone

17. You may name someone to be your authorized representative. This person must be at least 18 years old. He/She will be able to act in your behalf regarding your application and all other actions concerning your case. This person may be a friend, relative, neighbor, or legal representative/entity. You may choose an authorized representative at a later date if you do not wish to name one now. Do you want to name an authorized representative at this time? ☐ Yes ☐ No

If you answered **Yes**, please provide information about your authorized representative. **Please provide a copy of identification of your authorized representative.**

Name		Age	Address	
City	State		Zip Code	Phone

Use this space for additional information.