



Ohio Benefits Self-Service Portal Registration and Application Guide February 2020

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Disclaimer: Content is subject to change based on updates from Ohio Department of Job and Family Services and Ohio Department of Medicaid.

Visit the Ohio Benefits website to apply, reapply, and make updates to Food, Medical, and Cash Assistance cases.

Ohio | Benefits

Ohio.gov State Agencies | Online Services | Contact Us
English | Español | Somali

Custom Search

Welcome to Ohio Benefits

Use this site to manage or apply for healthcare, child care, food and cash benefits.

APPLY NOW

CHECK ELIGIBILITY

MANAGE BENEFITS*

To manage your child care benefits please contact your local county Department of Jobs and Family Services

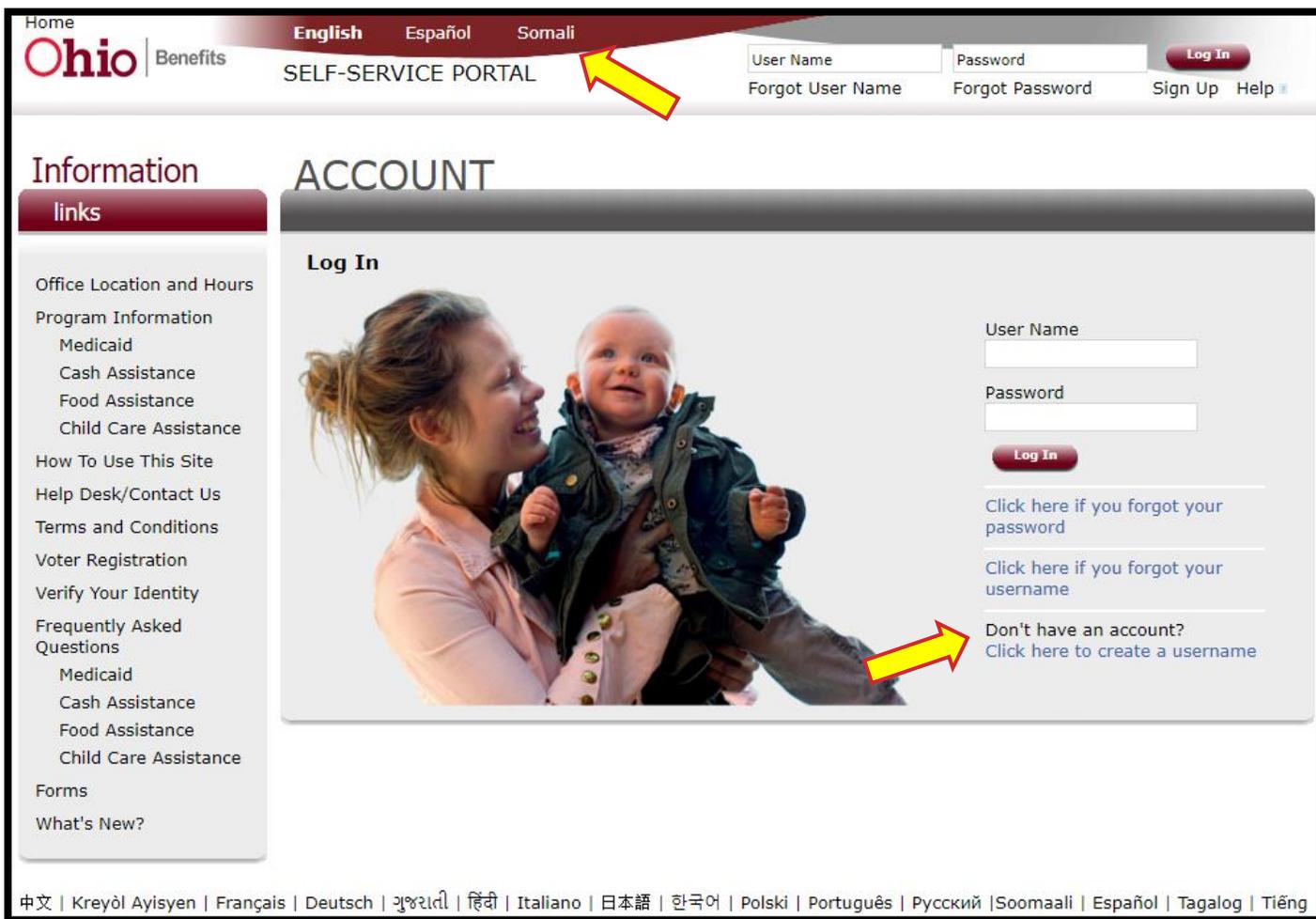
Ohio Medicaid is undergoing a Disability Determination Redesign. [Learn more.](#)

 **Veteran Benefits**
If you or your spouse served in the US military, you may be eligible for Veteran benefits. [Learn More.](#)

Benefits.Ohio.Gov

Helping Ohio residents find and apply for benefits. [Learn more.](#)

In order to apply or update a case, an Ohio Benefits Self-Service Portal account must be created.



The Ohio Benefits Self-Service Portal (OBSSP) can be accessed in English, Spanish, and Somali, by clicking the language links at the top of the screen.

Home **Ohio** Benefits English Español Somali SELF-SERVICE PORTAL User Name Password Log In Forgot User Name Forgot Password Sign Up Help

Information links

- Office Location and Hours
- Program Information
 - Medicaid
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- How To Use This Site
- Help Desk/Contact Us
- Terms and Conditions
- Voter Registration
- Verify Your Identity
- Frequently Asked Questions
 - Medicaid
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- Forms
- What's New?

ACCOUNT

Personal Information

Personal Information Contact Information Sign Up

The information provided in this section is only for managing your online profile.

* Red asterisk indicates required

First Name*

Middle Name/Initial

Last Name*

Suffix

Date of Birth (mm/dd/yyyy)

Social Security Number (123-45-6789)

Providing your SSN may help speed up the application process

The following link provides more detailed information about your rights and responsibilities for the programs: [Program Enrollment & Benefit Information - JFS 07501](#).

The following link provides more detailed information about how to use this site: [How to Use This Site](#)

Cancel Save and Continue



Information that has a * red asterisk indicates a required field.

Log In

Forgot User Name

Forgot Password

Sign Up

Help

ACCOUNT

Contact Information

Personal Information

Contact Information

Sign Up

The information provided in this section is only for managing your online profile.

* Red asterisk indicates required

Home Phone Number (999)999-9999

Mobile Phone Number (999)999-9999

Optional Email (example@abc.com)

If you do not have an email account and would like to create one, the links below will help get you started.

[Outlook](#)

[Gmail](#)

[Yahoo](#)

Mailing Address Line 1 *

Mailing Address Line 2

Mailing City *

Mailing State *

Ohio

Mailing Zip Code (#####) *

Is your home address the same as your mailing address?*

Yes No

I would like to receive notification of messages through

Text Message

Personal Email

You will receive messages related to your application or ongoing case in the self-service portal message center.

Back

Cancel

Save and Continue



ACCOUNT

Sign Up

Personal Information

Contact Information

Sign Up

- The username cannot contain special characters, such as, <>, #, |, &, ~, ?, (), {}, %, or *.
- The password must be at least eight (8) characters and contain at least one (1) character of each of the following four (4) characteristics:
 - Upper Case (A-Z)
 - Lower Case (a-z)
 - Numerals (0-9)
 - Special characters (for example: !, \$, #, or %)
- Special characters can be created by holding down the shift key plus the number key that shows your special character at the same time.
- The password cannot contain the Username.

When changing your password:

- The password cannot be one of previous twenty-four (24) passwords.
- The password cannot be changed more than one time per day.

You will be automatically logged in upon successful sign up.

* Red asterisk indicates required

Username *

Password *

Confirm Password *

Select Security questions for which you know the answer. If you forget your password, you will be asked to answer these questions to recover your password.

First Security question *

Answer *

Second Security question *

Answer *

Before you submit your request, you must read and agree to the following [Terms and Conditions](#)

* I have read and agree to the Terms of Use and Conditions



Back Cancel Sign Up



ACCOUNT

Sign Up Success

Thank you for signing up.
You have successfully created your username and password.

Identity Verification: Verifying your identity electronically is not required in order to apply for any kind of assistance. However, verifying your identity may allow us to determine if you are eligible for medical assistance as you complete your application. Identity verification also allows you to complete the annual renewal process for Medicaid online.

If you want to verify your identity, you can begin the process by clicking 'Continue'. If you have a problem during the process, you can stop the identify verification process and move on to filling out an application by clicking the Home / Ohio Benefits icon in the upper left-hand corner of the page. If you do not want to attempt identity verification, you can immediately begin the application process. To do this, click the Home / Ohio Benefits icon in the upper left-hand corner of the page, and then click on 'Apply for assistance' to start your application.

Continue



Once an account is created, the user will be directed to the Self-Service Portal to Log In. They will see the following screen options. The top right section of the screen allows for the User Name and Password that was previously created, to be entered.

Home
Ohio Benefits | English Español Somali

SELF-SERVICE PORTAL

User Name Password Log In
Forgot User Name Forgot Password Sign Up Help

Information links

- Office Location and Hours
- Program Information
 - Medicaid
 - Cash Assistance
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- How To Use This Site
- Help Desk/Contact Us
- Terms and Conditions
- Verify Your Identity
- Frequently Asked Questions
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- Forms
- What's New?

CHECK
Medicaid, Food & Cash Eligibility
What benefits could I receive?

APPLY
Medicaid, Food & Cash Benefits
Apply for assistance.

ACCESS
Medicaid, Food & Cash Benefits
Access will be granted upon log in.

CHECK
Early Childhood Services Eligibility
What services could my family receive?

APPLY
Child Care Benefits
Apply for assistance.

Once logged into the Self-Service Portal, there are available options to check eligibility, apply for assistance, view current application status, link the user account to an existing case, and apply for Child Care benefits.

Home **Ohio** Benefits **English** Español Somali SELF-SERVICE PORTAL 9 | Help | My Account | Log Out

Message [Open](#)
9 New Message(s)

Information links

- Office Location and Hours
- Program Information
 - Medicaid
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- How To Use This Site
- Help Desk/Contact Us
- Terms and Conditions
- Voter Registration
- Authorized Representatives
- Verify Your Identity
- Frequently Asked Questions
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- Forms
- What's New?

CHECK
Medicaid, Food & Cash Eligibility


- What benefits could I receive?

APPLY
Medicaid, Food & Cash Benefits


- Apply for assistance
- View application status

ACCESS
Medicaid, Food & Cash Benefits


- Link My Case(s)

CHECK
Early Childhood Services Eligibility


- What services could my family receive?

APPLY
Child Care Benefits


- Apply for assistance

Once **Apply for Assistance** is selected in the Medicaid, Food & Cash Benefits section, a screen that verifies the user's identity is displayed.

English Español Somali TRN 02 Environment TRN02 Version : 3.0.2.B Build :

SELF-SERVICE PORTAL Help | My Account | [Redacted] | Log Out

VERIFY

your identity

Verify Your Identity

The following information will be used to verify your identity.

First Name	[Redacted]
Middle Name/Initial	[Redacted]
Last Name	[Redacted]
Suffix	[Redacted]
Date of Birth (mm/dd/yyyy)	03/07/1983
Social Security Number (ie 123-45-6789)	[Redacted]
Address Line 1	[Redacted]
Address Line 2	[Redacted]
City	CLEVELAND
State	OH
Zip Code (#####)	11111
Home Phone Number (999)999-9999	[Redacted]

[Continue](#)

The next screen requests information on what type of benefit is being applied for; Medicaid, SNAP, or Cash or a Subsidized or Unsubsidized Qualified Health Plan.

The screenshot shows a web application interface. At the top, there is a navigation bar with language options: English, Español, and Somali. To the right, it displays 'TRN 02 Environment TRN02' and 'Version : 3.0.2.B Build :'. Below this is a header for 'SELF-SERVICE PORTAL' with links for 'Help', 'My Account', a redacted user ID, and 'Log Out'. The main content area is titled 'APPLY for benefits'. Underneath, there is a section for 'Household Application Information' with a prompt: 'Please tell us more about what the household is applying for.' A red asterisk indicates a required field. The question is: 'Is anyone in the household applying for Medicaid, SNAP (formerly known as food assistance or food stamps), or Cash Assistance? *'. Two radio button options are provided: 'Yes, at least one person is applying for Medicaid, SNAP, Or Cash Assistance' and 'No, the household would like to apply for a Subsidized or Unsubsidized Qualified Health Plan (QHP)'. At the bottom right of the form, there are 'Back' and 'Continue' buttons, with a yellow arrow pointing to the 'Continue' button.

This screen gives important information regarding the application process for each benefit program.

APPLY

for benefits

Let's get started

Here are some things to know before you start the application.

If you are applying for health care

To find out if you are eligible for health care coverage, we will be asking you a series of questions. These questions may be about you, the people who live in your home, and anyone else on your tax return (if you file taxes). We will ask for:

- Social Security Number (or document numbers for any legal immigrants who need and are applying for medical coverage). *It is strongly encouraged that you provide your accurate Social Security Number. Providing your SSN can be helpful even if you don't want health coverage, because it may speed up the application process. We use Social Security Numbers to check income and other information to see who's eligible for health coverage costs;*
- birth dates;
- employer & income information (it would be helpful to have pay stubs or forms such as W-2, Wage and Tax Statements);
- policy numbers for any current medical coverage; and
- information about any available job-related medical coverage.

As required by law, any information you provide will remain private.

If we are able to electronically verify the information you give us, we may be able to tell you whether or not you are eligible for Medicaid at the end of this application. Once we have determined your eligibility, you will receive a notice.

If you appear to be eligible for subsidized health coverage through the federal Marketplace, we will forward your information to the Federal government electronically.

If you get Medicaid after you turn 55 or while you are considered permanently institutionalized, after your death Medicaid will seek to be repaid from your estate for the cost of services and/or managed care premiums provided to you. ([Ohio Medicaid Estate Recovery - ODM 07408](#))

If You Are Applying For SNAP Or Cash Assistance

To find out if you are eligible for assistance, we will be asking you a series of questions. These questions

Beginning of Application

On this screen, individuals can access voter registration, enter contact information, as well as the specific benefit program(s) that are being applied for.

APPLY

for benefits

Voter Registration and Enter Personal Information

Welcome **Start Application** People Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 20.0%

* Red asterisk indicates required

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote? Yes No

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

Your answer to the above question will not affect your application for benefits in any way.

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

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

You can download a voter registration form by clicking here: [Voter Registration Form](#), or you can register online.

To register online, you will need to provide the following information:

- Ohio driver's license or Ohio identification card
- Name
- Date of Birth
- Address
- Last four digits of your Social Security Number

Click here to register to vote online: [Register to Vote](#).

You can review the Voter Registration Notice of Rights and Declination by clicking here: [Voter Registration Notice of Rights](#).

For help with this process or filling out the form, you may contact the toll-free Help Desk (1-844-640-OHIO) or the Ohio Secretary of State's toll-free number (1-877-SOS-OHIO/1-877-767-6446). You may also call or visit your local county office.

The Primary Applicant's name, contact information, and address information is pre-populated from their OBSSP user account. Ensure this is correct before continuing.

Applicant's Information				
First Name*	Middle Name	Last Name*	Suffix	Maiden Name
<input type="text" value="████████"/>	<input type="text"/>	<input type="text" value="████████"/>	<input type="text" value=""/>	<input type="text"/>
Contact Information				
Home Phone Number (999)999-9999	Mobile Phone Number (999)999-9999	Personal Email Address(example@abc.com)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
You will receive messages related to your application or ongoing case in the self-service portal message center. I would like to receive notification of messages through <input type="checkbox"/> Personal Email				
Address Information				
Mailing Address Line 1 *				
<input type="text" value="████████"/>				
Mailing Address Line 2				
<input type="text"/>				
Mailing City *	Mailing State *	Mailing Zip Code (#####) *		
<input type="text" value="CLEVELAND"/>	<input type="text" value="Ohio"/>	<input type="text" value="11111"/>		
Is your home address the same as your mailing address? *				
<input checked="" type="radio"/> Yes <input type="radio"/> No				

For the Program Information section, answer **Yes** if the person completing this online application is the applicant or an assister. If the Authorized Representative is completing this online application, answer **No** because you are acting on behalf of the applicant.

Program Information
Are you applying for benefits for yourself?*
<i>If you are an Authorized Representative, please select No and add the people you represent on the People chevron.</i>
<input checked="" type="radio"/> Yes <input type="radio"/> No

This screen is a continuation of the previous screen when **Yes** is selected for the Program Information question. Check the boxes for Medical, SNAP, or Cash Assistance, and additional information will be populated under each selection. Then press, Save and Continue.

What benefits are you applying for?*

- Medical Coverage for yourself
Do you owe medical bills from the last 3 months?
 Yes No
- SNAP
If a person applies for SNAP and any other program, they may at any time return to this page and select SNAP only.
- Cash Assistance

Cash assistance includes two programs. Ohio Works First (OWF) is for families with minor children or women who are at least six months pregnant. Families without a minor child will not be eligible for OWF. Refugee Cash Assistance is for refugees who are in their first eight months in the U.S. Individuals not in their first eight months since entrance will not be eligible for RCA.

[Back](#) [Save and Continue](#)

This screen will populate for SNAP applicants. It is to determine if this application will be considered for expedited processing.

APPLY for benefits

Expedited SNAP

Welcome **Start Application** People Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 20.0%

These questions will help the county to decide if you qualify to receive SNAP benefits more quickly. Please answer the following questions for only the people who buy, fix and eat meals with you.

██████████

Is your total gross income before taxes for the current month less than \$150? Yes No

Are your total resources in cash, checking, and savings accounts less than \$100? Yes No

Are you a migrant or seasonal farm worker? Yes No

Are your monthly rent or mortgage and utilities (such as gas, electric, water, and phone) more than your total monthly gross income before taxes? Yes No

Is your total net income after taxes and paying for such things as housing costs, child/dependent care costs, or child support payments for the current month zero? Yes No

[Back](#) [Save and Continue](#)

As each screen of the application is completed, the progress bar will show the completion percentage. As a reminder, there are * red asterisks on screens to show required information, but the more information that is completed on the application, the smoother the application process can go.

English Español Somali TRN 02 Environment TRN02 Version : 3.0.2.B Build :

SELF-SERVICE PORTAL Help | My Account | [Redacted] | Log Out

APPLY for benefits

Tell us More

Welcome Start Application People Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 20.0%

Please give us additional information about yourself. Fields with an * are required; however, you are encouraged to provide as much information as possible in order to assist with determining eligibility.

[Redacted]

Are you male or female?* Male Female

Date of Birth (mm/dd/yyyy)* 03/07/1983

Social Security Number (123-45-6789)
Providing your SSN may help speed up the application process

Please select a reason why you do not have an SSN: Select One

Is the first and last name you provided the same name that appears on your Social Security card? Yes No

Are you a U.S. Citizen or National?* Yes No

Marital Status Select One

Are you known by another name? Yes No

Do you buy, fix and eat meals with the other people that live with you?
If you do not buy, fix and eat meals with other people that live with you then you may need to complete separate applications. Yes No

Do you have a physical or mental impairment that significantly limits one or more major life activities? Yes No

Are you blind? Yes No

Are you requesting Medicaid home and community-based services or institutional care? Yes No

Back Save and Continue

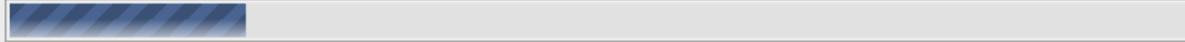
APPLY

for benefits

Background Information



Percent Complete: 20.0%



Please give us additional information about yourself. As long as a response is not required, you can skip it.

Title VI of the Civil Rights Act of 1964 allows us to ask for racial/ethnic information. If you do not provide this information it will have no effect on your case, however, if you do not provide this information, a worker will enter a response for you.

* Red asterisk indicates required

[Redacted]

Are you a resident of Ohio?*

Yes No

What is your preferred spoken language?

Select One

What is your preferred written language?

Select One

What is your race? (Optional)

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Are you Hispanic or Latino?

Yes No

Back Save and Continue

After each section, a review screen will appear. This screen will show answers that were given, and allow for edits.

APPLY

for benefits

Start Application Summary

Welcome **Start Application** People Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 20.0%

[Show All](#) | [Hide All](#)

Expedited SNAP Hide Details

Is your total gross income before taxes for the current month less than \$150? No

Are your total resources in cash, checking, and savings accounts less than \$100? No

Are you a migrant or seasonal farm worker? No

Are your monthly rent or mortgage and utilities (such as gas, electric, water, and phone) more than your total monthly gross income before taxes? No

Is your total net income after taxes and paying for such things as housing costs, child/dependent care costs, or child support payments for the current month zero? No

[Edit](#)

Tell us More Hide Details

Are you male or female?* Female

Date of Birth (mm/dd/yyyy)* 03/07/1983

Social Security Number (123-45-6789) ***-**-****

Providing your SSN may help speed up the application process

Please select a reason why you do not have an SSN:

Is the first and last name you provided the same name that appears on your Social Security card? Yes

Are you a U.S. Citizen or National?* Yes

Marital Status Single - Never Married

Are you known by another name? No

Do you buy, fix and eat meals with the other people that live with you? No

If you do not buy, fix and eat meals with other people that live with you then you may need to complete separate applications.

Do you have a physical or mental impairment that significantly limits one or more major life activities? No

Add any additional household members on the **People Summary** page.

On the **People Summary** page, Authorized Representatives are instructed to add the applicant and any other person as described in the paragraph above. **DO NOT** add the Primary Applicant again. The system will generate an error stating that the social security number has already been entered. Simply add any other household members.

English Español Somali TRN 02 Environment TRN02 Version : 3.0.2.B Build :

SELF-SERVICE PORTAL Help ? | My Account | [Redacted] | Log Out

APPLY for benefits

People Summary

Welcome Start Application **People** Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 30.0%

Primary Applicant [Redacted]

Does anyone else live in your home?

If so, please add each person that lives with you even if they are not applying. If you are applying for medical coverage, and you file a federal income tax return, also include anyone on your federal income tax return, even if that person doesn't live with you.

If you are an authorized representative, add the applicant and any other person as described above.

Save and Exit Add Another Person Save and Continue

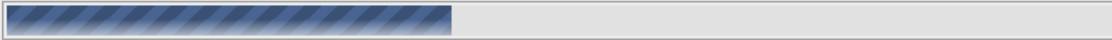
APPLY

for benefits

Job Information



Percent Complete: 40.0%



Next we will ask you some questions about the people in your home that have a job, attend school or are in training.

[Redacted]

Is anyone in the household (including children) going to school, college, or in training? Yes No

Is anyone on strike? Yes No

Is there anyone in the home working, self-employed, or who will receive earned income in the next 30 days? Yes No

Has anyone left a job in the last 90 days? Yes No



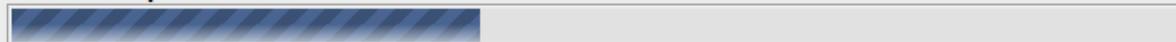
APPLY

for benefits

Job and Job History



Percent Complete: 40.0%



You told us that at least one person in your home is working, self-employed, or will receive earned income in the next 30 days. Please enter that information below.
 To add another job entry for current employment for the same person, or to add a job entry for a different person in the household, please click 'Save and Continue' and then on the next page, Job and Job History Summary, click 'Add Another Entry'.

* Red asterisk indicates required

Select a person

Work or Training:* Work Training

Start Date (mm/dd/yyyy)?*

End Date (mm/dd/yyyy)?

Employer Name*

Job Title

Number of Hours Worked per week*

Pay period frequency*

Gross Income (before taxes) per pay period*



This screen asks about other sources of income. If a Yes answer is provided additional questions will be asked.

APPLY

for benefits

Income Information

Welcome Start Application People Job and School **Other Income** Expenses Resources Other Submit Application

Percent Complete: 50.0%

In the next few pages we will ask you about the people in your home who earn or get money.

*If you are applying for SNAP or Cash Assistance you will need to provide verification of your **Supplemental Security Income (SSI)** or **Veteran's Benefits (VA)**. If you are applying for Medicaid, you are not required to provide information about your **Supplemental Security Income (SSI)** or **Veteran's Benefits (VA)** unless you are applying for coverage based on age (over 65), blindness, disability, or need for Long-Term Care.*

■■■■■■■■■■ SSI

Does anyone in the household plan to file a tax return this year? Yes No

Will anyone in the household be claimed as a dependent on a tax return next year? Yes No

Is anyone in the home (including children) going to get money from any of these? Yes No

- Supplemental Security Income (SSI)
- Social Security Disability
- Social Security Retirement
- Social Security Survivors
- Railroad Retirement
- Railroad Retirement Disability
- Railroad Retirement Survivors
- Private Pensions
- Deferred Comp
- Government Employee
- 401K
- Individual Retirement Account(IRA)
- Roth Individual Retirement Account(Roth IRA)
- Annuity
- Veteran Aid and Attendance
- Veteran Disability - Partial
- Veteran Disability - Total

Is anyone in the home (including children) going to get money from any of these? Yes No

- Child Support
- Alimony/Spousal Support

Is anyone in the home (including children) going to get money from any of these? Yes No

- HUD Payment
- Loan, gifts, contributions
- Work Compensation
- Legal or Insurance settlements/court actions pending
- Meals and/or room
- Strike Pay/Benefits
- Termination/Severance Pay
- Foster Care - Title IV - E
- Foster Care - Title IV - B/XX
- Adoption Assistance Subsidy - Title IV - E
- Adoption Assistance Subsidy - Non Title IV - E
- Sales of Notes, Contracts, Trust Deeds, or Promissory Notes
- Winnings such as Bingo, Lottery or Prizes

Does anyone in the home receive any money from educational grants, loans and/or scholarships, work study or training allowances? Yes No

Has anyone in the home applied for or received disability insurance benefits in the last 12 months? Yes No

Does anyone in the home get housing, rent, utilities, food, or clothing free or in exchange for work? Yes No

Does anyone in the home (including children) get any other income that is not listed above? Yes No

Is anyone's month to month income not steady? Yes No

Back

Save and Continue



APPLY

for benefits

Tax information about the people in your home



We may use the federal tax info to see if you can get Medicaid. Tell us more by filling in the information below.

[Redacted] s

Does this person plan to file a tax return for the income earned in this year?

Select One

[Back](#) [Save and Continue](#)



APPLY

for benefits

Tax information about the people in your home continued



Percent Complete: 50.0%



We may use the federal tax info to see if you can get Medicaid. Tell us more by filling in the information below.

If you select a tax filing status of "Married - Filing Jointly", you will be asked to select the joint filer. If the joint filer is not in the dropdown return to the people pages and add the person to the application.



What filing status will this person use for a Federal tax return for the current year?*

Select One 

Will this person be claimed as a dependent on someone else's tax return? Yes No

OTHER DEPENDENTS

Will this person claim one or more dependents not listed on this application? Yes No

[Back](#) [Save and Continue](#)



APPLY

for benefits

Tax Information Summary



Percent Complete: 50.0%

Show All | Hide All

Tax information about the people in your home continued

Hide Details

What filing status will this person use for a Federal tax return for the current year?* Single

Will this person be claimed as a dependent on someone else's tax return?

OTHER DEPENDENTS

Will this person claim one or more dependents not listed on this application?

Edit

Back

Continue



Are there any expenses? This list will vary based on what is being applied for.

English Español Somali TRN 02 Environment TRN02 Version : 3.0.2.B Build :

SELF-SERVICE PORTAL Help ? | My Account | [REDACTED] | Log Out

APPLY

for benefits

Expenses Information

Welcome Start Application People Job and School Other Income **Expenses** Resources Other Submit Application

Percent Complete: 60.0%

In the next few pages we will ask you about the people in your home who have expenses. Does anyone in your home pay for:

[REDACTED] \$

Dependent Care Expenses (Child, Adult or Elder Care)?	<input type="radio"/> Yes <input type="radio"/> No
Housing Expenses?	<input type="radio"/> Yes <input type="radio"/> No
Medical Expenses?	<input type="radio"/> Yes <input type="radio"/> No
Medicare Coverage Expenses?*	<input type="radio"/> Yes <input type="radio"/> No
School Expenses (Tuition, Books or Transportation)?	<input type="radio"/> Yes <input type="radio"/> No
Support Expenses (Child/Spousal)?	<input type="radio"/> Yes <input type="radio"/> No
Utility Expense (Gas, Electricity, Water, etc.)?	<input type="radio"/> Yes <input type="radio"/> No
Self-Employment Expenses?	<input type="radio"/> Yes <input type="radio"/> No

[Back](#) [Save and Continue](#)



APPLY for benefits

Resource Information



Percent Complete: 70.0%



In the next few pages we will ask you about the people in your home who have resources

████████████████████

Do you or anyone in the household have any of the following liquid resources? Yes No

- 401(K) Keogh/IRA/Retirement/Pension
- ABLE Account
- Agency Payment Card - *Please report the current balance on any card from any government agency*
- Annuity Accounts
- Bonds
- Burial Insurance
- Burial Space
- Cash/Uncashed Check/Uncashed Funds
- Certificate of Deposit (CD)
- Checking Account
- Facility Entrance Fee
- Life Insurance - Term
- Life Insurance - Universal
- Life Insurance - Whole
- Liquid Asset of Alien Sponsor - *Please report any liquid resources available to the alien sponsor such as bank accounts, cash on hand, stocks, bonds, etc.*
- Long Term Care (LTC) Insurance
- Money Market
- Mortgage/Deeds (Other than the home you live in)
- Mutual Funds
- Preneed Funeral Contract
- Promissory Notes
- Real property sold on land contract
- Savings/Credit Union Account
- Social Security Back-Pay Lump Sum
- Stocks
- Tribal Gaming Ongoing Disbursements
- Trust

Do you or anyone in the household have any of the following real estate resources? Yes No

- Building
- House/Condominium
- Land
- Life Estate
- Lot - Vacant
- Lot with Buildings
- Mobile Home
- Real Estate Property of Alien Sponsor

Have you or anyone in the household sold, traded or given away any resource in the last 5 years?

Yes No

Do you or anyone in the household own any of the following types of personal property?

Yes No

- Crops
- Livestock
- Personal Property of Alien Sponsor
- Poultry
- Tools

Does anyone own or have their name on the registration of any motor vehicle, even if not running?

Yes No

Back

Save and Continue



APPLY

for benefits

Household Relationships



Percent Complete: 80.0%



Listed below are all members of your household entered on the application. If any household member is missing, please return to the People Tab and add them. When all household members have been listed, please tell us each person's relationship to one another. This information is required to process your application.

* Red asterisk indicates required

Note: 'Spouse' means that you have been married according to the laws of Ohio or have been married in another State and your marriage would be recognized under Ohio law.

There is no other household member identified to have a relationship with. Please go back and Add Another Person if you have missed anyone.

Back

Save and Continue



If an Authorized Representative is being added, answer **Yes** on the Other Information page to “Do you want to name someone as your authorized representative or allow someone to receive your benefit card(s)?”

English Español Somali TRN 02 Environment TRN02 Version : 3.0.2.B Build :

SELF-SERVICE PORTAL Help | My Account | [REDACTED] | Log Out

APPLY for benefits

Other Information

Welcome Start Application People Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 80.0%

In the next few pages we will ask you additional questions about the people in the home.

[REDACTED] S

Does anyone live in any of these places? * Yes No

- Alcohol and Drug Treatment Facility
- Assisted Living Facility
- Campus Housing with meals provided
- Federally Subsidized Housing
- Group Living Arrangement for the Disabled/Blind
- Homeless Shelter
- Hospital
- Nursing Home / Intermediate Care Facility for Individuals with Development Disabilities
- Psychiatric Hospital/Mental Institution
- Shelter for Battered Women

Have Cash Assistance or SNAP benefits been stopped for anyone because of: Yes No

- Work or Training Sanctions
- Failure to meet Able-Bodied Adult Without Dependent (ABAWD) Work Requirements
- Intentional Program violation or Welfare Fraud

Is anyone incarcerated (detained or jailed)? Yes No

Do you want to name someone as your authorized representative or allow someone to receive your benefit card(s)? Yes No

An authorized representative must be 18 years of age or older, can act on you and your household's behalf and receives all notifications you do.

Back Save and Continue



If the authorized representative is not already listed on the application, enter their information, select the program(s), and level of authorization. An end date of authorization can also be entered.

No new messages.

Information links

- Office Location and Hours
- Program Information
 - Medicaid
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance

Add an Authorized Representative

Welcome Start Application People Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 80.0%

Provide details for the Authorized Representative and the benefit program(s)

* Red Asterisk indicates a required field

Authorized Representative Information

Jane M Doe

Is this someone already listed on the application? Yes No

- Medicaid
- Cash Assistance
- Food Assistance
- Child Care Assistance
- How To Use This Site
- Help Desk/Contact Us
- Terms and Conditions
- Voter Registration
- Authorized Representatives
- Verify Your Identity
- Frequently Asked Questions
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- Forms
- What's New?

Authorized Representative Information

Jane M Doe

Is this someone already listed on the application? Yes No

First Name: James

Middle Name:

Last Name: Doe

Suffix: Select One

Does this person represent an Assisting or Community-based organization? Yes No

Assisting Organization Name: Organization xyz

What is this person's relationship to you? Unrelated

Home Phone (999)999-9999: (216)555-9999

Mobile Phone (999)999-9999:

Personal Email Address (example@abc.com):

Spoken Language: English

Written Language: English

Mailing Address Line 1: 123 Lane Rd

Mailing Address Line 2:

City: Cleveland

State: OH

ZIP Code (99999): 44115

Select which program(s) you want this person to access on your behalf: SNAP Only

Select the level of authorization this person or company has to act on your behalf:

Take any needed action to ensure I receive or continue to receive benefits (e.g. Receive all notices, represent me at hearings, attend/schedule interviews on my behalf, submit my verifications, apply for benefits on my behalf, etc.)

Receive my SNAP Benefits

Select the date when this person will no longer be your Authorized Representative: (mm/dd/yyyy)

APPLY for benefits

Other Information Continued

Welcome

Start
Application

People

Job and
School

Other
Income

Expenses

Resources

Other

Submit
Application

Percent Complete: 80.0%

In the next few pages we will ask you additional questions about the people in your home.

Is anyone currently fleeing from felony prosecution, fleeing from high misdemeanor prosecution in New Jersey, or violating conditions of probation or parole? Yes No

Is anyone currently getting benefits, or has gotten benefits in the past, from another state? Yes No

Has anyone served, or is anyone currently serving in the U.S. Military? * Yes No

Does anyone have a medical condition or emotional problem as a result from an accident or injury? Yes No

Does anyone have another health insurance now, including Veterans, Medicaid or CHIP, COBRA, Private/Other, Retiree Health Plan? Yes No

Back

Save and Continue

If the individual that is requesting benefits has someone assisting them to apply, this information would need to be completed.

English Español Somali TRN 02 Environment TRN02 Version : 3.0.2.B Build :

SELF-SERVICE PORTAL Help | My Account | [REDACTED] | Log Out

APPLY

for benefits

Assisting Organization or Person

Welcome Start Application People Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 100%

You are about to complete the application. Please answer a few questions.

Did anyone help you complete this application? Yes No

 [Back](#) [Save and Continue](#)

You are about to complete the application. Please answer a few questions.

Did anyone help you complete this application? Yes No

For Your Information

Applicant – Person applying for benefits
Authorized Representative – Representative acting on behalf of the applicant
Non-Applicant – Helper to the person applying for benefits

Please tell us more information about who helped you complete the application

Name of Organization	Organization Type	
<input type="text"/>	Select One	
Name of Person Helping You	Select One	
First Name	Community Food Bank	
<input type="text"/>	Community Health Clinic	
Phone Number	Hospital Advocate/Social Worker	
<input type="text"/>	Housing Office	
Address Line 1	Other Type of Organization	
<input type="text"/>	State or County Agency	
Address Line 2	Email	
<input type="text"/>	<input type="text"/>	
City	State	Zip Code (#####)
<input type="text"/>	Ohio	<input type="text"/>

[Back](#) [Save and Continue](#)

An information page of which county office will receive the application will be shown.

English Español Somali TRN 02 Environment TRN02 Version : 3.0.2.B Build :

SELF-SERVICE PORTAL Help ? | My Account | [REDACTED] | Log Out

APPLY

for benefits

Office Selection

Welcome Start Application People Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 100%

Based on your county of residence, your application will be sent to the following county agency for processing. To find additional locations to drop off verification please click on the Office Locations and Hours link to the left.

Any time an appointment or interview is scheduled, it can be in-person or over the phone.

SUMMIT County
37 N HIGH ST
AKRON OH 44308
Hours
[Mon, Tue, Wed, Thur, Fri] 8:00 am-4:45 pm

Back Save and Continue

There is an option to upload documents for verification. This list of documents on this page is a generic list.

English Español Somali TRN 02 Environment TRN02 Version : 3.0.2.B Build :

SELF-SERVICE PORTAL Help | My Account | [Redacted] | Log Out

APPLY for benefits

Verifications Documents

Welcome Start Application People Job and School Other Income Expenses Resources Other Submit Application

Percent Complete: 100%

Within the next 10 days, the worker assigned to your application may ask you to give proof of the information you told us in your application. Look at the list below for some examples of documents you can provide.

- Proof of Disability Status
- Proof of School Grants or Loans
- Proof of Citizenship or Alien Status
- Proof of Pregnancy and Number of Fetuses
- Proof of Resources
- Proof of Resource Transfer
- Proof of Subsidized Rent/Utilities
- Proof of Third Party Medical Coverage Information
- Proof of Housing/Utility Cost
- Proof of Medical Expenses, to include Insurance Premium Amounts
- Proof of Income
- Proof of Identity
- Proof of Address
- Military Credentials
- Proof of Social Security Number
- Proof of Child Support Paid
- Proof of Dependent Care Costs
- Healthcheck and Pregnancy Related Services Information Sheet
- Other

If you have copies of these documents available now, please electronically attach them to your application. To do this, click on the Browse button below. The more complete your application is when you submit it, the faster a worker will be able to process it.

The following document type extensions may be uploaded: .afp, .bmp, .doc, .docx, .gif, .jpg, .jpeg, .pdf, .png, .tif, .tiff, .txt, .xls, .xlsx.

File Size Limit is 10MB.

Document Type Select one [Dropdown] Browse... No file selected.

Back Save and Continue

The signature page contains a lot of important information such as; stating information is true, authorization for electronic verifications, privacy and discrimination practices. This page must be signed to submit the application.

In the signature section, the applicant should be typing their name and selecting **Applicant** in the Description field. If the Authorized Representative is completing the application, they should type their name and select **Authorized Representative** in the Description field.

APPLY for benefits

E-Signature



Percent Complete: 100%

Read all the information below very carefully. When you are done, check the checkbox on the bottom to indicate that you agree that all the information that you provided in the application is accurate. You can still change information on your application now; however, once you click 'Submit Application' button below this will submit your application and you won't be able to make any further changes.

Note: Please fill all the mandatory() fields before submitting the application.*

Certification

- I understand the questions on this form.
- I understand that any facts that I have given, including benefit and income facts, will be matched with local, state, and federal records, such as employers, the Social Security Administration, tax, welfare, and unemployment agencies, etc. and for cash aid and food stamps, records will be matched with law enforcement agencies for arrest warrants.
- I understand that the county will send information to the U.S. Citizenship and Immigration Service (USCIS) for verification of noncitizen status, and to the Social Security Administration to check work quarters information for noncitizens applying for benefits.
- I understand that the information the county gets from USCIS and/or Social Security may affect my eligibility for benefits.
- I understand information, including benefit and income facts, that I have given on this form is subject to investigation and review by county, state, and federal personnel and that if I give incorrect facts my benefits may be denied or stopped.
- I understand that I must apply for and keep any available health coverage if no cost is involved; if I do not my Medicaid will be denied or stopped.
- I understand that if I have opted to have an Authorized Representative, I authorize this person or organization to take any action that may be needed to ensure that I receive or continue to receive benefits from the County Department of Job and Family Services, Ohio Department of Job and Family Services or the Ohio Department of Medicaid, and to act on my behalf in all other matters with the agency (or those agencies). This includes but is not limited to receiving a copy of all correspondence sent to me, submitting verifications on my behalf, submitting applications and renewing benefits, representing me at a state hearing, and discussing my financial and medical information, including any protected health information (PHI) that relates to my receipt of benefits.
- I understand that the county 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 county in writing that I wish to end my authorization.
- If I refuse to authorize the county to get information about me from financial institutions, or decide to end my authorization, I understand that my medical assistance may be denied or discontinued.

SNAP and Cash Assistance Programs

For a copy of the Notice of Privacy Practices, please call out Ohio Medicaid Consumer Hotline toll free at (800)324-8680 or by visiting our web site at

<http://www.medicaid.ohio.gov/FOROHIOANS/AlreadyCovered/NoticeofPrivacyPractices.aspx>

* I declare under penalty of perjury under the laws of the United States of America that the information contained in this statement of facts is true, correct and complete.

Check to Sign*	Name*	Description
<input type="checkbox"/>	<input type="text"/>	<div style="border: 1px solid black; padding: 2px;"><p>Applicant</p><p>Applicant</p><p>Authorized Representative</p><p>Non-Applicant</p></div> <p>Description selects: Applicant – Person applying for benefits Authorized Representative – Representative acting on behalf of the applicant Non-Applicant – Helper to the person applying for benefits</p>

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form, \(AD-3027\)](#), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the [State Information/Hotline Numbers](#) (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

[Back](#) [Submit Application](#)

Check Eligibility Option

The option is available to put in general information before applying to see if there is potential eligibility for Medical, Food, or Cash. Chose this option from the Ohio Benefits Home Page or Self-Service Portal Page.

English Español Somali TRN 02 Environment TRN02 Version : 3.0.2.B Build :

SELF-SERVICE PORTAL Help ? | My Account | [REDACTED] | Log Out

CHECK eligibility

Welcome!

Welcome to the Self Assessment. The tool is a quick and easy way for you to find out if your household might be able to get:

- Low or no cost health care
- Help paying Medicare premiums
- SNAP(formerly known as food assistance or food stamps)
- Cash Assistance

Your answers to a few short questions will let you know if your household might be eligible for benefits. Complete the questions based on your household's conditions now. Estimates are allowed, but they need to be as correct as possible.

If you, or anyone in your household, has a need for or interest in long-term services and supports, please click [here](#).

After finishing the Assessment, you can review your answers and change them if necessary. The self-assessment can only tell you that your household may qualify for benefits and services; it is not a promise that you will receive them. In order for us to determine whether you are actually eligible for benefits and services, there are other steps that must be taken. You must submit an application for us to determine whether you qualify for benefits and services.

[Begin Assessment](#)

CHECK eligibility

Financial Information

* Red asterisk indicates required

How many adults are in your household?*

Select One ▾

Is anyone age 60 or older?*

Yes No

How many children are in your household?*

Select One ▾

How much total money (before taxes) did all of the people in your household get last month?*

How much cash does the household have on hand? Include cash, money in checking accounts and saving accounts, etc.*

How much does the household pay for medical expenses monthly?*

Are any household members United States Citizens?*

Yes No

If not, does anyone who is not a US Citizen have legal documentation?*

Yes No

Does anyone have a disability? *

Yes No

Is anyone pregnant?*

Yes No

Is anyone in the household enrolled in Medicare?*

Yes No

[Back](#) [Continue](#)



Application Status

To review the status of an application submitted, log into the Ohio Benefits Self-Service Portal and Under the Apply option there is an option to View Status.

The screenshot displays the Ohio Benefits Self-Service Portal interface. At the top, there is a navigation bar with 'Home', 'Ohio Benefits', and language options: 'English', 'Español', and 'Somali'. The main header reads 'SELF-SERVICE PORTAL'. On the right side of the header, there are links for '9 | Help', 'My Account', and 'Log Out'. On the left side, there is a 'Message' section with '9 New Message(s)' and an 'Information links' section containing various service categories like 'Office Location and Hours', 'Program Information', 'Medicaid', 'Cash Assistance', 'Food Assistance', 'Child Care Assistance', 'How To Use This Site', 'Help Desk/Contact Us', 'Terms and Conditions', 'Voter Registration', 'Authorized Representatives', 'Verify Your Identity', 'Frequently Asked Questions', 'Forms', and 'What's New?'. The main content area features four large tiles. The top-left tile is titled 'CHECK Medicaid, Food & Cash Eligibility' and includes a photo of a woman holding a baby. The top-right tile is titled 'APPLY Medicaid, Food & Cash Benefits' and includes a photo of a diverse group of children. The bottom-left tile is titled 'CHECK Early Childhood Services Eligibility' and includes a photo of four children. The bottom-right tile is titled 'APPLY Child Care Benefits' and includes a photo of three children. A yellow arrow points from the 'CHECK Medicaid, Food & Cash Eligibility' tile to the 'APPLY Medicaid, Food & Cash Benefits' tile. The 'APPLY Medicaid, Food & Cash Benefits' tile contains a list of options: 'Apply for assistance' and 'View application status'. The 'APPLY Child Care Benefits' tile contains a list of options: 'Apply for assistance'.

Home | **Ohio** Benefits | English | Español | Somali | SELF-SERVICE PORTAL | 9 | Help | My Account | Log Out

Message | Open | 9 New Message(s)

Information links

- Office Location and Hours
- Program Information
 - Medicaid
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- How To Use This Site
- Help Desk/Contact Us
- Terms and Conditions
- Voter Registration
- Authorized Representatives
- Verify Your Identity
- Frequently Asked Questions
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- Forms
- What's New?

CHECK Medicaid, Food & Cash Eligibility

- What benefits could I receive?

APPLY Medicaid, Food & Cash Benefits

- Apply for assistance
- View application status

ACCESS Medicaid, Food & Cash Benefits

- Link My Case(s)

CHECK Early Childhood Services Eligibility

- What services could my family receive?

APPLY Child Care Benefits

- Apply for assistance

APPLY

for benefits

View Application Status

You can search for applications by selecting the required date range and clicking the 'search' button.

* Red asterisk indicates required

Submitted Date Range*

Last 30 days

Search

Application Date	Program	Application Number	Action
Not Submitted	Medicaid, SNAP	2036364	View

Results 1 of 1

Back

Authorized Rep Request

After logging into the Ohio Benefits Self-Service Portal, there is an option to input Authorized Representative information.

The screenshot displays the Ohio Benefits Self-Service Portal interface. At the top, there are language options: English, Español, and Somali. The main navigation bar includes 'Home', 'Ohio Benefits', 'SELF-SERVICE PORTAL', 'Help', 'My Account', and 'Log Out'. A left-hand navigation menu lists various links, with 'Authorized Representatives' highlighted by a red arrow. The main content area is divided into four service categories: 'CHECK Medicaid, Food & Cash Eligibility', 'APPLY Medicaid, Food & Cash Benefits', 'ACCESS Medicaid, Food & Cash Benefits', and 'APPLY Child Care Benefits'. Each category includes a representative image and a list of available actions.

Information links

- Office Location and Hours
- Program Information
 - Medicaid
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- How To Use This Site
- Help Desk/Contact Us
- Terms and Conditions
- Authorized Representatives**
- Voter Registration
- Verify Your Identity
- Frequently Asked Questions
 - Medicaid
 - Cash Assistance
 - Food Assistance
 - Child Care Assistance
- Forms
- What's New?

CHECK
Medicaid, Food & Cash Eligibility

- What benefits could I receive?

APPLY
Medicaid, Food & Cash Benefits

- Apply for assistance
- View application status

ACCESS
Medicaid, Food & Cash Benefits

- Link My Case(s)

APPLY
Child Care Benefits

- Apply for assistance

中文 | Kreyòl Ayisyen | Français | Deutsch | ગુજરાતી | हिंदी | Italiano | 日本語 | 한국어 | Polski | Português | Русский | Soomaali | Español | Tagalog | Tiếng

DETAILS

Authorized Representative Request

In order to view and manage benefit information for a benefit recipient online, you must submit a request to link your account.

In order to link your account, you must already be an active Authorized Representative on the case.

In order to become an Authorized Representative, you must be 18 years of age and the benefit recipient must designate you to act on their behalf, in writing.

*Red asterisk indicates a required field

First Name **Middle Name** **Last Name** **Suffix**

██████████ M ██████████

Do you represent an Assisting or Community-Based Organization?* Yes No

Organization Name*

Identity Validation

While the following information is not required to be an Authorized Representative, it may be required to verify your identity when applying for or managing a Medicaid case on behalf of another person.

Date of Birth (mm/dd/yyyy)

Social Security Number (i.e. 123-45-6789)

Contact Information

Home Phone Number

(999)999-9999

Mobile Phone Number

(999)999-9999

Email Address

(example@abc.com)

I would like to receive messages through
(Note: You will still receive paper copies of all notices)

Email

Applying for Child Care Benefits

In the Child Care Benefits section, select “Apply for assistance”.

The screenshot shows the Ohio Benefits SELF-SERVICE PORTAL. At the top, there are language options: English, Español, and Somali. The main navigation bar includes 'Home', 'Ohio Benefits', and 'SELF-SERVICE PORTAL'. On the right, there are links for '9' (notifications), 'Help', 'My Account', and 'Log Out'. A left sidebar contains sections for 'Message' (with an 'Open' button and '9 New Message(s)'), 'Information links', and a list of services: Office Location and Hours, Program Information (Medicaid, Cash Assistance, Food Assistance, Child Care Assistance), How To Use This Site, Help Desk/Contact Us, Terms and Conditions, Voter Registration, Authorized Representatives, Verify Your Identity, Frequently Asked Questions (Cash Assistance, Food Assistance, Child Care Assistance), Forms, and What's New? The main content area features six service tiles arranged in a 2x3 grid. The top row includes: 1. 'CHECK Medicaid, Food & Cash Eligibility' with an image of a woman holding a baby and a bullet point: 'What benefits could I receive?'; 2. 'APPLY Medicaid, Food & Cash Benefits' with an image of four children and bullet points: 'Apply for assistance' and 'View application status'; 3. 'ACCESS Medicaid, Food & Cash Benefits' with an image of a family and a bullet point: 'Link My Case(s)'. The bottom row includes: 4. 'CHECK Early Childhood Services Eligibility' with an image of four children and a bullet point: 'What services could my family receive?'; 5. 'APPLY Child Care Benefits' with an image of three children and a bullet point: 'Apply for assistance', which is highlighted by a red arrow.

Review the Application and Provider FAQs, then select Begin Application.

The screenshot displays the Ohio Benefits SELF-SERVICE PORTAL. At the top, there are navigation options for Home, English, Español, and Somali. The main header includes the Ohio logo, 'Benefits', and 'SELF-SERVICE PORTAL'. On the right side of the header, there are links for '9' (notifications), 'Help', 'My Account', and 'Log Out'. The left sidebar contains sections for 'Message' (with an 'Open' button and '9 New Message(s)'), 'Information links', and a list of links including 'Office Location and Hours', 'Program Information' (Medicaid, Cash Assistance, Food Assistance, Child Care Assistance), 'How To Use This Site', 'Help Desk/Contact Us', 'Terms and Conditions', 'Voter Registration', 'Authorized Representatives', 'Verify Your Identity', 'Frequently Asked Questions' (Cash Assistance, Food Assistance, Child Care Assistance), 'Forms', and 'What's New?'. The main content area is titled 'APPLY for benefits' and features a progress bar with steps: Welcome, About You, Emergency Contact, Household, Income / Activity, Who Needs Care, Summary, and e-Sign. The current step is 'Application and Provider FAQs'. Below this, there is a section titled 'Getting started with this application' with an upward arrow. The text explains that information is not saved during data entry and that the browser will time-out after 15 minutes. It also notes that it's important to gather information before logging in. A section titled 'Before starting your application, you will need:' lists requirements such as names and social security numbers of household members, emergency contact information, employer/school information, child care provider information, and income sources. A final paragraph states that the application must be complete before submission and will be sent electronically to the county agency. At the bottom, there is a section titled 'How do I apply for assistance?' with a downward arrow.

What will I need to do after submission? ▼

When will my eligibility begin? ▼

How do I get help with completing this application? ▼

What verification do I need? ▼

How do I choose a child care provider? ▼

How do I make a complaint about a provider? ▼

What if my child has a disability or I suspect my child may be developmentally delayed? ▼

What is Step Up To Quality?

- Step Up To Quality helps families identify child care programs that go beyond the minimum standards of licensing. Star Rated programs demonstrate higher levels of quality in a variety of ways.
- For more information, visit our website at <http://jfs.ohio.gov/cdc/index.stm>.



Begin Application

The application for child care benefits will begin with the About You section.

The screenshot shows the Ohio Benefits SELF-SERVICE PORTAL. At the top, there are navigation links for Home, English, Español, and Somali. The main header includes the Ohio logo, 'Benefits', and 'SELF-SERVICE PORTAL'. On the right, there are links for '9' messages, 'Help', 'My Account', and 'Log Out'. A left sidebar contains a 'Message' section with '9 New Message(s)' and an 'Information links' section with various service links. The main content area is titled 'APPLY for benefits' and features a progress bar with steps: Welcome, About You (current), Emergency Contact, Household, Income / Activity, Who Needs Care, Summary, and e-Sign. The 'About You' section asks if the user wants to register to vote, with two radio button options: 'Yes, I want to register to vote.' and 'No, I do not want to register to vote.' Below this, there is a note that if no box is selected, the user will be considered to have decided not to register. The form includes a section for '* Required Fields' with the heading 'Tell Us about yourself(the applicant)'. It contains input fields for 'First Name *', 'MI', and 'Last Name *', a 'Date of Birth' field with a calendar icon, and a 'Mailing Address *' field.

City * County * State * Zip *

Is your mailing address different from street address? *

Home Phone Number

Cell Phone Number

Work Phone Number

May we send text messages to your cell phone number?

Email Address

Are you:

Visually Impaired

Hearing Impaired

Do you need any of the following services?

Interpreter

Sign Language

Other

Once all required fields are completed, select Next Step.

What is your preferred language?

Spoken:

Written:

Marital Status

Do you and the people in your home have more than one million total dollars in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?

Are you or anyone in your household in the military?

Have you ever been found guilty of child care fraud?

Do you currently have an Ohio Works First (OWF) Self-Sufficiency Plan?

If you are a minor, are you currently in LEAP?

Do you have any college credit hours?

[Back](#)



Complete the Emergency Contact section and select Next Step.

Home **Ohio** Benefits **English** Español Somali **SELF-SERVICE PORTAL** 9 | [Help](#) | [My Account](#) [Log Out](#)

Message [Open](#)
9 New Message(s)

Information links
Office Location and Hours
Program Information
Medicaid
Cash Assistance
Food Assistance
Child Care Assistance
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APPLY for benefits

Application for Child Care Benefits

Welcome About You **Emergency Contact** Household Income / Activity Who Needs Care Summary e-Sign

Emergency Contact

Not Applicable

First Name **MI** **Last Name**

Street Address

City **County** **State** **Zip**

Home Phone Number **Cell Phone Number** **Work Phone Number**

May we send text messages to your cell phone number?

Email Address

[Back](#) **Next Step**

List information about household members.

The screenshot shows the Ohio Benefits SELF-SERVICE PORTAL. At the top, there are navigation options for Home, English, Español, and Somali. The main header includes the Ohio logo, 'Benefits', and 'SELF-SERVICE PORTAL'. On the right, there are links for '9' (with a star icon), 'Help', 'My Account', and 'Log Out'. The left sidebar contains a 'Message' section with '9 New Message(s)' and an 'Open' button, and an 'Information links' section with various service links. The main content area is titled 'APPLY for benefits' and shows a progress bar with steps: Welcome, About You, Emergency Contact, Household (highlighted), Income / Activity, Who Needs Care, Summary, and e-Sign. Below the progress bar, the text reads: 'Tell us about everyone that lives in your home. You must list everyone who lives with you, even if they are not applying. Please include information on all children including those that do not need care.' The 'Household Members' section displays a table for the 'Primary Applicant' with the following details:

Primary Applicant		▼
Date of Birth	03/07/1983	Edit
SSN		
Have you received any assistance?		
US Citizen		
Gender		
Relationship to You	Primary Applicant	
Race		
Hispanic or Latino		
Highest Level of Education		
Graduation Date		

First Name

Last Name

Date of Birth

Social Security Number (optional)

Have you ever received cash, child care, food, or medical assistance?

US Citizen?

Gender

Relationship to You (spouse, son, etc.)

Race

Hispanic or Latino?

Highest Level of Education Completed

Graduation Date

Add Household Member



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[Next Step](#)

Input information about income and qualifying activities.

Home **Ohio** Benefits SELF-SERVICE PORTAL English Español Somali

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Message Open

9 New Message(s)

Information links

- Office Location and Hours
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Welcome About You Emergency Contact Household **Income / Activity** Who Needs Care Summary e-Sign

Tell us about your qualifying income and activities

Please complete this section if you or the people in your home are working, attending school or participating in a training program. If employed, please provide the current employer and any employer each household member has worked for since your last application for child care assistance. This includes self-employment and odd jobs. If attending school or a training program, please also provide verification of your schedule.

Select Household Member

--

First Name **Last Name**

Job Title

Start Date **End Date**

Employer/School/Training Site Name

Input information about the child(ren) that are in need of care.

Home **Ohio** Benefits English Español Somali SELF-SERVICE PORTAL 9 | Help | My Account | Log Out

Message [Open](#)
9 New Message(s)

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Application for Child Care Benefits

Welcome About You Emergency Contact Household Income / Activity **Who Needs Care** Summary e-Sign

Tell us about the child(ren) who need care

Select Household Member
--

First Name **MI** **Last Name**

Child's Mother's Maiden Name

Child's City of Birth

Relationship to Applicant
--

Child's Preferred Spoken Language
--

Review all of the information that was entered the e-Sign your application.

Home **Ohio** Benefits **English** Español Somali **SELF-SERVICE PORTAL** 9 | Help | My Account | Log Out

Message

Open

9 New Message(s)

Information links

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APPLY for benefits

Application for Child Care Benefits

Welcome About You Emergency Contact Household Income / Activity Who Needs Care Summary **e-Sign**

e-Sign your application

Your Rights and Responsibilities

I understand that this application will be considered without regard to race, color, ancestry, sex, age, handicap, religion or national origin. To the best of my knowledge and belief, the answers on this application are complete and correct. I understand that the law provides penalty of fine or imprisonment, or both, for anyone convicted of accepting assistance for which he or she is not eligible. I state under penalty of perjury that all information is true and complete to the best of my knowledge.

By signing and submitting the application I acknowledge and agree that the county agency and ODJFS may share certain details about the status of my application with the child care provider listed in "Who needs care" section of this application and any amendment thereto, as well as to any child care provider who I authorize to receive information regarding my application.

My signature below gives my consent to the agency and the ODJFS to make contacts that are necessary to determine my eligibility for assistance and to verify the information I have given in this application. I understand that my signature below gives the county agency permission to access available information in the Support Enforcement Tracking System (SETS) to verify my child / spousal / medical support income. My signature also gives consent to issue a system generated statewide student identifier (SSID) for each child listed in "Who needs care" section of this application.

My signature below gives my consent and authorizes the county agency to access CRIS-E or Ohio Benefits Worker Portal for the purpose of verifying the citizenship status of the children in this case and for verification of the receipt of additional public assistance. I may revoke this authorization at any time by notifying the county agency in writing.

I understand that I will be able to use publicly funded child care benefits only for children who are eligible and only up to the maximum hours authorized by the county agency. To remain eligible for publicly funded child care benefits, the required copayment (if applicable) must be paid by me to the provider. Failure to pay the required copayment may result in termination of publicly funded child care benefits.

I understand that any change which affects child care eligibility, that I must report changes to the county agency including a change in family income, a change in hours of employment/training/education, a change in family size, and a change of address. I understand that I must report changes within 10 days of the date the change occurs.

I understand that if I am approved, I will be responsible for accurately recording my child's attendance at the child care program by utilizing an automated attendance tracking system. This includes registering in the system and creating personal identification information that I will use to access the system and to serve as my electronic signature. I understand that my child care provider is not permitted to record my child's attendance on my behalf, and may not have access to my personal identification information. I understand that the attendance tracking system may take my photo or a photo of my designee/sponsor as part of the login and logout process. I understand that I am responsible for approving any changes that my provider makes in the attendance tracking system regarding my child's attendance at the program.

I understand that if my child attends a Step Up To Quality rated program, and if an assessment is completed on my child, the data will be collected and reported to ODJFS.

I have received an explanation regarding the requirements for determining eligibility, the reasons why I may not be eligible, my right to a state hearing, my responsibility for reporting changes to the county agency and the penalty, including possible civil action or criminal prosecution, for the intentional withholding or falsification of information or misuse of child care benefits, including misuse of the automated child care attendance tracking system.

Child care fraud is the willful withholding or falsification of information or misuse of child care services as determined by a court of law. Failure to meet this reporting requirement may be considered fraud and may result in the following: 1) repayment of child care benefits which you received but for which you were not eligible; 2) termination or denial of child care benefits; or 3) penalty of fine and/or imprisonment if convicted of fraudulently receiving child care benefits for which you were not eligible.

Signature of Applicant *

I have read and understand my Rights and Responsibilities ... *



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[Submit Application](#)

By signing this application for Publicly Funded Child Care benefits electronically, I certify under penalty of perjury that my answers are true and accurate to the best of my knowledge, including information about citizenship or alien status for each child needing care. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

You will receive a copy of the above rights and responsibilities with the submission receipt.