Ohio Administrative Code

Rule 5160:1-2-01 Medicaid: administrative agency responsibilities.

Effective: January 26, 2024

(A) This rule describes the responsibilities of the administrative agency.

(B) Calculation of time periods for eligibility determinations. All calculations of time periods used in the determination of eligibility, including an annual renewal or a redetermination as a result of a reported change, shall be computed as follows:

(1) When counting the number of days in a specified time period, the initial day is excluded from the computation and the last day is included.

(2) When the last day of the time period falls on a Saturday, Sunday, or legal holiday, the time period shall end on the next business day.

(C) Effective date of applications, reported information, or requests for applications or assistance. Applications, documents, or information submitted or provided to the administrative agency, or requests made to the administrative agency, are considered received by the administrative agency:

(1) That day, when received by the administrative agency or the electronic eligibility system during the administrative agency's business hours.

(2) On the next business day, when received by the administrative agency or the electronic eligibility system after the administrative agency's business hours or on a non-business day when the administrative agency is closed.

(D) Request for application. When an individual requests an application, the administrative agency shall:

(1) Not deny an individual's right to apply or discourage an individual from applying.

(2) Inform the individual of the following:

(a) An online application portal is available to complete an application for medical assistance and application assistance is available through the portal.

(b) The beginning date of benefits depends on the date the signed application is received by the administrative agency.

(c) The verification requirements and deadlines.

(d) Individuals shall cooperate with eligibility determinations, renewals, redeterminations, audits, and quality control processes as defined in this chapter of the Administrative Code.

(e) The meaning of and penalties for medicaid eligibility fraud as set forth in section 2913.401 of the Revised Code.

(f) The Ohio attorney general (AGO) shall seek recovery or adjustment on behalf of the administrative agency from the estate of the following individuals, as set forth in rule 5160:1-2-07 of the Administrative Code:

(i) A permanently institutionalized individual of any age; or

(ii) An individual fifty-five years of age or older who is not permanently institutionalized.

(3) Fulfill a request for an application within one business day.

(a) Fulfillment occurs when the administrative agency sends an electronic copy of the application or a link to an electronic copy of the application to the text or email address provided by the individual; hands the application to the individual; or places the application in the U.S. mail. When the application is provided in person or via U.S. mail, the administrative agency shall enclose a preaddressed, postage-paid envelope for return of the application.

(b) The application shall be accompanied by:

(i) The JFS 07217 "Voter Registration Notice of Rights and Declination" (rev. 5/2022) or a notice meeting the requirements of section 3503.10 of the Revised Code, and a voter registration form as required by section 329.051 of the Revised Code; and

(ii) The ODM 07400 "Ohio Medicaid Estate Recovery" (rev. 5/2023); and

(iii) The JFS 07501 "Program Enrollment and Benefit Information" (rev. 4/2022).

(E) Upon receipt of a request for assistance or receipt of an application, the administrative agency shall:

(1) Make program information available and accessible to an individual upon request, consistent with 42 C.F.R. 435.905 (as in effect October 1, 2022):

(a) Provide language services at no cost to an individual with limited English proficiency, including oral interpretation and written translations; and

(b) Provide auxiliary aids and services at no cost to an individual living with a disability in accordance with the Americans with Disabilities Act of 1990 (ADA) (Pub. L. No. 101-336) and section 504 of the Rehabilitation Act of 1973 (Pub. L. No. 93-112).

(2) Distribute voter information and registration materials as required by 42 C.F.R. 431.307 (as in effect October 1, 2022).

(3) Coordinate with the special supplemental nutrition program for women, infants and children (WIC) as required by 42 C.F.R. 431.635 (as in effect October 1, 2022) to ensure written notice of the availability of the WIC program is provided to an individual determined eligible for medical assistance, including an individual who is presumptively eligible and is also a potential WIC recipient.

(a) The administrative agency shall advise a potential WIC recipient of the WIC program and refer the individual to the WIC agency by forwarding a copy of the individual's medical assistance

application and any supplemental application, unless the individual is already receiving WIC assistance.

(b) For an individual already in receipt of medical assistance who is a potential WIC recipient, the administrative agency shall advise the individual of the WIC program at least annually.

(c) The following individuals are potential WIC recipients:

(i) A woman who is:

(A) Pregnant; or

(B) Within a six-month period after giving birth; or

(C) Breastfeeding her infant within twelve months after the infant's birth; or

(ii) A child younger than five years old.

(F) Assistance.

(1) The administrative agency shall allow a person or persons of the individual's choice to accompany, assist with, and represent the individual in the application, redetermination, or annual renewal process.

(a) A person may accompany and assist an individual without being an individual's authorized representative.

(b) The administrative agency shall not reveal confidential information, as described in rule 5160-1-32 of the Administrative Code, or send notices or correspondence to the person assisting the individual, unless the person has been designated in writing as an authorized representative.

(c) A person who is assisting an individual shall provide accurate information, to the best of his or her knowledge, regardless of whether the person is an authorized representative.

(2) When an individual has designated in writing an authorized representative, the administrative agency shall:

(a) Issue all notices and correspondence to both the authorized representative and the individual.

(b) Contact the individual to clarify or verify information provided by an authorized representative when the information provided on the application seems contradictory, unclear, or unrealistic.

(c) Remove the authorized representative from any correspondence or access to safeguarded information upon receipt of notice that:

(i) The authorized representative is declining or ending representation of the individual; or

(ii) The individual has withdrawn the authorized representative's authority.

(3) The administrative agency shall help complete the application when assistance is needed, including assistance through agents of the administrative agency, such as eligibility workers.

(a) At the individual's request, an eligibility worker shall assist with completing the application by asking the individual for answers needed to complete the application, then recording the individual's answers on the application form or in the electronic eligibility system. The eligibility worker shall not alter any answers given by the individual.

(b) When an eligibility worker assists with or helps complete an application, the worker shall sign the application form and include the worker's title as a person who assisted with completing the application.

(c) The process of inputting data into the electronic eligibility system or determining an individual's eligibility shall not be construed as providing assistance.

(4) Upon request, the administrative agency shall provide assistance to individuals having difficulty gathering verifications.

(5) When determining eligibility for an individual with a physical or mental impairment that substantially limits the individual's ability to access verifications, and who has not granted any person durable power of attorney, or who does not have a court-appointed guardian or a person with other legal authority and obligation to act on behalf of the individual, the administrative agency shall:

(a) Explore whether another person is available to assist the individual with obtaining verifications or accessing the individual's means of self-support. For an individual who resides in a nursing facility (NF), explore whether the person who signed the NF admission contract is able to assist the individual.

(i) When a person is available to assist the individual, request the person assist with obtaining the verifications or accessing the individual's means of self-support.

(ii) When verifications are provided, or when means of self-support are able to be accessed by the individual or on the individual's behalf by another person, the administrative agency shall consider the verified criteria or means of self-support in the eligibility determination process.

(b) When no person with the ability to access the individual's means of self-support is available to assist the individual:

(i) Refer the individual's case to the administrative agency's legal counsel and request counsel evaluate whether the matter should be referred to the probate court, adult protective services, or another entity deemed by the administrative agency's legal counsel to be appropriate. For cases referred to counsel for such evaluation, the administrative agency shall also:

(A) Note in the individual's case record that verifications or means of self-support are not available and shall not be considered a disqualifying factor until a means of access to those items is obtained or established; and

(B) Inform the administrative agency's legal counsel of any eligibility approval or denial.

(ii) Determine eligibility in accordance with Chapter 5160:1-2 of the Administrative Code, but without considering eligibility factors for which verification cannot be obtained or means of self-support cannot be accessed because of the individual's physical or mental impairment. Use the most reliable information available without delaying the determination of eligibility.

(iii) Redetermine eligibility once a means of access to verifications or means of self-support is obtained or established. When such access has not been obtained prior to the individual's annual renewal, determine continuing eligibility using the most reliable information available.

(G) Receipt of application. Upon receipt of a signed application for medical assistance or for specific medical assistance services or programs, the administrative agency shall:

(1) Give or send a receipt to the individual showing the date of application.

(2) Accept and register the application within one business day of the time the signed application is received. Only an application signed under penalty of perjury in accordance with 42 C.F.R. 435.907 (as in effect October 1, 2022) is considered valid.

(a) Acceptable signatures for an application include:

(i) An original handwritten signature; and

(ii) An "electronic signature" or "e-signature," that includes electronic sounds, symbols, or processes attached to or logically associated with records and executed or adopted by individuals with the intent to sign a record. An electronic signature satisfies legal requirements in accordance with section 1306.06 of the Revised Code and includes:

(A) An audio or "telephonically recorded" signature obtained in accordance with procedures approved by the Ohio department of job and family services (ODJFS) that is retrievable and complies with federal record retention requirements in accordance with 7 C.F.R. 272.1(f) (as in effect October 1, 2022); and

(B) A signature submitted electronically as part of the online medical assistance application process;

and

(C) A handwritten signature transmitted via any other electronic transmission, such as through email or facsimile; and

(D) A rubber stamp that replaces a signature for an individual who has an inability to sign in accordance with the Rehabilitation Act of 1973 (Pub. L. No. 93-112); and

(E) When the signatory cannot sign with a name, an "X" is a valid signature; and

(F) An electronically signed application received from the federally facilitated marketplace (FFM); and

(G) An electronically signed application received from the social security administration (SSA) for the low-income subsidy (LIS) program.

(b) An individual who applies for health coverage through the FFM will be assessed for medicaid eligibility with the signature provided to the FFM.

(3) When an application is received from a local WIC clinic, maternal, child and family health (MCFH) clinic, or the children with medical handicaps program (CMH) office within five business days of the signature date, the application shall be registered using the signature date. When the application is not received within five business days of the signature date, the application shall be registered using the date the application was received by the administrative agency.

(4) When an application taken by an outstationed worker assigned to a federally qualified health center (FQHC) or a disproportionate share hospital (DSH) is not directly entered into the electronic eligibility system, the application shall immediately be submitted to the appropriate administrative agency, which shall register the application using the signature date.

(5) The administrative agency shall not delay the registration or processing of an application due to the lack of a signed acknowledgment of an individual's rights and responsibilities.

(6) As required by section 329.051 of the Revised Code, the administrative agency shall:

(a) Give or send a notice meeting the requirements of section 3503.10 of the Revised Code or the JFS 07217 "Voter Registration Notice of Rights and Declination" (rev. 5/2022); and

(b) Give or send the "Voter Registration Information and Update Form" (undated) as prescribed by the secretary of state.

(H) Verifications. Where manual verifications are required under rule 5160:1-2-10 of the Administrative Code, the administrative agency shall:

(1) Follow the safeguarding guidelines set forth in rule 5160-1-32 of the Administrative Code when providing or gathering information by telephone, in person, or in electronic or written form.

(2) Not require that an individual provide verification of unchanged information unless the information is incomplete, inaccurate, inconsistent, outdated, or missing from the case record due to record retention limitations.

(3) Not request that an individual provide duplicate copies of previously submitted verifications.

(4) To the extent possible, verify relevant eligibility criteria using electronic records available through the electronic eligibility system and other electronic data sources. Where electronic verification is not available, or electronic verification data conflicts with the individual's attestation, request verifications as set out in rule 5160:1-2-10 of the Administrative Code.

(5) When the administrative agency is unable to verify eligibility criteria through electronic sources, the administrative agency shall contact the individual to collect information needed to process the application, redetermination, or annual renewal. When the individual declares the verifications cannot be accessed or submitted, the individual's statement shall be accepted. When the administrative agency is unable to make contact with the individual, a written (electronic or on paper) request for the necessary information or verification documents shall be sent.

(a) The written request shall:

(i) Include the date by which the information must be provided to the administrative agency; and

(ii) Inform the individual that any delay in providing requested information or documents will delay the determination of an individual's eligibility; and

(iii) Provide information regarding how an individual can request assistance from the administrative agency with gathering the requested documents.

(b) When the information or verification required to establish the individual's eligibility for assistance is not received by the administrative agency by the stated date, the administrative agency shall contact the individual in writing no more than twenty calendar days following the date of the application, redetermination, or annual renewal.

(i) The follow-up request for information or verification documents:

(A) Shall be sent electronically, via postal mail, or personally delivered to the individual. When sent via postal mail or personally delivered, the administrative agency shall enclose a preaddressed, postage-paid envelope for return of the verification(s); and

(B) Shall state that the required information or verification has not been received and that when the information or verification is not received within ten calendar days the administrative agency shall deny or discontinue the application, redetermination, or annual renewal for medical assistance; and

(C) Shall include a clear statement that the administrative agency will assist with obtaining the required information or verification when the request for assistance is received on or prior to the given deadline; and

(D) Does not serve as a notice of denial of the application or discontinuance of benefits.

(ii) When the requested information or verification is not received by the stated deadline, the administrative agency shall propose a denial or discontinuance of benefits.

(c) The administrative agency shall deny the individual's application when the individual fails to provide the necessary information or verifications, or request assistance and cooperate with obtaining verifications, within the time specified in the second verification request. When this happens:

(i) An individual may reapply at any time.

(ii) An individual shall not be asked to re-verify information previously verified by the administrative agency without reason to believe the information may have changed.

(6) Give or send a dated itemized receipt that lists each verification document received from an individual.

(7) Record receipt of all verification documents, photocopy or scan the documents, and retain copies or images of the documents in the case record.

(8) When information is verified through a telephone contact, record the following details:

(a) The name and telephone number of the person providing the information; and

(b) The name of the agency or business contacted, when applicable; and

(c) The date of the contact; and

(d) An accurate summary of the information provided.

(I) Determination, redetermination, and renewal of eligibility. The administrative agency shall:

(1) Not schedule an interview except at the request of the individual.

(2) Inform all individuals at the time of application and renewal that the agency will obtain and use information available from the income and eligibility verification system (IEVS) to assist with the determination of eligibility, as required by section 1137 of the Social Security Act (as in effect October 1, 2022).

(3) Require a signature for all renewals of medical assistance where eligibility was not passively renewed using the electronic eligibility system.

(4) Using the electronic eligibility system, the administrative agency shall:

(a) Determine eligibility or renewal of an individual's eligibility for medical assistance within the application processing time limits set forth in this rule.

(i) The administrative agency shall not approve medical assistance to an individual merely because of an agency error or delay in determining eligibility. All eligibility factors shall be met.

(ii) The administrative agency shall not delay the approval of medical assistance due to the lack of information or verifications necessary to determine eligibility for other public assistance programs.

(b) Document and record determinations of eligibility. The administrative agency shall:

(i) Record, in physical or electronic case records, any information, action, decision, or delay in the application, eligibility determination, or discontinuance processes, as well as the reasons for any action, decision, or delay.

(ii) Make the case records, physical or electronic, available for compliance audits.

(c) Approve medical assistance for an individual who:

(i) Has signed an application under penalty of perjury; and

(ii) Has provided all necessary verifications as set forth in rule 5160:1-2-10 of the Administrative Code; and

(iii) Meets all conditions of eligibility for a medical assistance category set forth in Chapter 5160:1-2, 5160:1-3, 5160:1-4, 5160:1-5, or 5160:1-6 of the Administrative Code. When an individual who attests to U.S. citizenship or qualified non-citizen status meets all conditions of eligibility for a

medical assistance category except for verification of the individual's citizenship or qualified non-citizen status, the administrative agency shall approve time-limited coverage during a reasonable opportunity period (ROP) as required in rule 5160:1-2-11 or 5160:1-2-12 of the Administrative Code.

(d) Deny an application for medical assistance for an individual who:

(i) Has not signed an application under penalty of perjury; or

(ii) Withdraws the application; or

(iii) Fails to cooperate with the application or determination process or fails to provide all necessary verifications set forth in rule 5160:1-2-10 of the Administrative Code; or

(iv) Does not meet all conditions of eligibility for any medical assistance category set forth in Chapter 5160:1-2, 5160:1-3, 5160:1-4, 5160:1-5, or 5160:1-6 of the Administrative Code.

(e) Suspend medical assistance upon notification that an individual meets any of the criteria for ineligibility for payment of services set forth in rule 5160:1-1-03 of the Administrative Code.

(f) Discontinue medical assistance for an individual who:

(i) Requests that assistance be discontinued; or

(ii) Is no longer an Ohio resident; or

(iii) Is deceased; or

(iv) Fails to cooperate with the renewal process; or

(v) Fails to cooperate with the quality control process; or

(vi) Fails to provide all necessary verifications; or

(vii) Is eligible as a result of an administrative agency error; or

(viii) Provided fraudulent information or verifications; or

(ix) Fails or refuses to comply with individual responsibilities as described in this chapter of the Administrative Code; or

(x) No longer meets the conditions of eligibility outlined in rule 5160:1-2-10 of the Administrative Code for any medical assistance category set forth in Chapter 5160:1-2, 5160:1-3, 5160:1-4, 5160:1-5, or 5160:1-6 of the Administrative Code. Before discontinuing coverage on this basis, the administrative agency shall conduct a pre-termination review (PTR) as defined in rule 5160:1-1-01 of the Administrative Code to determine that the individual is no longer eligible for coverage under any eligibility category.

(g) Administratively close an invalid application. An application form received without an acceptable signature is considered invalid and shall be administratively closed and not receive a notice of action (NOA) or hearing rights.

(J) Reinstatement of medical assistance.

(1) When an individual cooperates with the renewal process, the administrative agency shall:

(a) Reinstate medical assistance, discontinued for failure to cooperate with the renewal process or verification of a reported change, within ninety calendar days of the discontinuance date without requiring a new application in accordance with 42 C.F.R. 435.916(a)(3)(C)(iii) (as in effect October 1, 2022).

(b) Accept the renewal form and/or verifications that caused the discontinuance of medical assistance.

(c) Reinstate medical assistance when all eligibility criteria are met.

(d) Reinstated medical assistance coverage shall begin on the first day of the calendar month following the month medical assistance was discontinued.

(2) When a hearing request is filed timely by an individual as outlined in division 5101:6 of the Administrative Code, the administrative agency shall reinstate medical assistance benefits at the same benefit level until a hearing decision is rendered in accordance with 42 C.F.R. 431.230 (as in effect October 1, 2022).

(K) Timely determinations and renewals. The administrative agency shall make a timely determination of an individual's eligibility for medical assistance under this chapter of the Administrative Code. The administrative agency shall determine initial eligibility or a renewal of eligibility, including obtaining verifications when required, within:

(1) Ten calendar days of receiving a report of a change that could affect an individual's ongoing eligibility for medical assistance; or

(2) Forty-five calendar days from the date of application or scheduled renewal, unless:

(a) An individual who otherwise meets the conditions of eligibility described in this chapter of the Administrative Code alleges blindness or disability. The administrative agency shall determine eligibility within ninety calendar days from the date of application unless the examining physician delays or fails to take a required action; or

(b) There is an administrative or other emergency beyond the administrative agency's control.

(3) Forty-five calendar days of receipt of new or changed information from IEVS. The administrative agency shall not deny or discontinue benefits until appropriate steps have been taken to verify the relevant information in accordance with 42 C.F.R. 435.952(d) (as in effect October 1, 2022).

(L) Effective dates of eligibility.

(1) Medical assistance coverage begins on the first day of the calendar month in which the application which resulted in eligibility was submitted to the administrative agency, except that:

(a) An individual's coverage cannot begin before the date on which the individual:

(i) Became a resident of Ohio; or

(ii) Was born.

(b) The administrative agency shall approve retroactive eligibility for medical assistance effective no later than the first day of the third month before the month of application when the individual:

(i) Reports he or she received medical services of a type covered by medical assistance within the three months prior to the application month; and

(ii) Requests retroactive eligibility be determined; and

(iii) Would have been eligible for medical assistance at the time the services were provided if an application had been made at that time, regardless of whether the individual was alive when the application actually was made. Actual income received in each retroactive month shall be used to determine eligibility for that month.

(iv) Is eligible for a category of medical assistance other than:

(A) Transitional medical assistance as described in rule 5160:1-4-05 of the Administrative Code; or

(B) Medicare premium assistance as described in rule 5160:1-3-02.1 of the Administrative Code; or

(C) Any presumptive eligibility category described in rule 5160:1-2-13 of the Administrative Code.

(2) Medical assistance coverage discontinues on the last day of a calendar month, except that coverage discontinues on the date an individual:

(a) Becomes a resident of another state; or

(b) Dies; or

(c) Requests that coverage be discontinued.

(M) Duration of eligibility span. The administrative agency shall:

(1) Discontinue coverage under a time-limited medical assistance category as described in the Administrative Code rule for the appropriate medical assistance category. These time-limited eligibility categories include:

(a) Any presumptive eligibility category, as described in rule 5160:1-2-13 of the Administrative Code, and

(b) Non-citizen emergency medical assistance (NCEMA), as described in rule 5160:1-5-06 of the Administrative Code, and

(c) Refugee medical assistance (RMA), as described in rule 5160:1-5-05 of the Administrative Code.

(2) Schedule an individual's renewal of eligibility for medical assistance twelve months after the most recent eligibility determination.

(3) Redetermine medical assistance upon receiving a report of, or identifying, a change in circumstances that could affect an individual's eligibility for medical assistance.

(N) Third party liability (TPL). For individuals found eligible for or in receipt of medical assistance, the administrative agency shall report to the Ohio department of medicaid (ODM) any available information about a third party liable for an individual's health care costs.

(1) When determining an individual's eligibility for medical assistance coverage, the agency shall use the form (or an electronic equivalent) designated by the administrative agency to report:

(a) Possible health insurance coverage of an individual. A separate report shall be made for each possible health insurance policy.

(b) Potential TPL due to an injury, disability, or court order.

(2) At renewal, or upon any reported or identified change, the administrative agency shall compare the individual's current information to the information on the most recent ODM 06612 "Health Insurance Information Sheet" (rev. 11/2020) or ODM 06613 "Accident/Injury Insurance Information" (rev. 7/2020). When any information has changed, the administrative agency shall report the changes to ODM by submitting a new ODM 06612 or ODM 06613, or an electronic equivalent.

(3) Upon a request by ODM, the administrative agency shall contact the individual to obtain information regarding potential TPL. When the individual fails to cooperate, the agency shall propose to deny or discontinue the individual's medical assistance for failure to cooperate, as set forth in paragraph (I)(4) of this rule.

(O) Upon a report (verbal or written) of a change of address within the state of Ohio, the administrative agency shall:

(1) Give or mail to the individual a notice meeting the voter registration requirements of section 3503.10 of the Revised Code and advise the individual that, upon request, the administrative agency will help the individual register to vote or update voter registration as outlined in rule 5101:1-2-15 of the Administrative Code.

(2) Process an intercounty transfer (ICT) when the individual has changed residence from one county to another. Both the county of original residence and the county of new residence have responsibilities in the ICT process. The ICT process shall be followed whether the individual reporting a change of residence is an individual or is currently in receipt of medical assistance benefits.

(a) The county department of job and family services (CDJFS) receiving report of a move shall determine whether the move is a change of residence or a temporary absence from the home. When the move is a temporary absence from the home, the county in which the individual is physically located shall provide necessary medical and transportation services.

(b) The CDJFS receiving report of a change of residence shall:

(i) Update the address in the electronic eligibility system. When the individual does not have an address in the new county, use the address of the administrative agency in the new county.

(ii) When the report is made to the administrative agency in the county of new residence, inform the county of original residence.

(c) Record requirements for intercounty transfers within the state.

(i) The CDJFS in the individual's original county of residence shall take the following actions for the identified type of case record:

(A) Electronic records. When the individual moves to another county within the state, the electronic document management system shall be updated with the most recent eligibility determination documentation no later than the end of the business day following the date the CDJFS becomes aware of the address change.

(B) Online records. Prior to the online record being transferred, the CDJFS in the individual's original county of residence shall ensure the electronic eligibility system is updated no later than the end of the business day following the date the CDJFS becomes aware of the address change.

(C) Hard copy records. Hard copy records used in the most recent eligibility determination shall be converted into digital format in the electronic document management system no later than the end of the business day following the date the CDJFS becomes aware of the address change. The remaining hard copy records shall be transferred no later than five calendar days following the date the CDJFS becomes aware of the address change. The CDJFS in the individual's original county of residence shall notify the CDJFS in the individual's county of new residence when a hard copy record is being transferred.

(ii) The case record to be transferred shall contain the following documents:

(A) The most recently signed application for medical assistance; and

(B) Other pertinent documents, such as citizenship, qualified non-citizen status, income, and resource verifications.

(d) The CDJFS in the individual's county of new residence shall:

(i) Not require the individual to reapply or cooperate with a renewal of eligibility for medical assistance merely due to the change in county of residence.

(ii) Verify potential changes in income, expenses, employment, or household composition resulting from the change in residence when the CDJFS that received the reported change did not complete the verification prior to the intercounty transfer.

(iii) Provide the medical assistance benefits for which the individual is eligible.

(e) When the case being transferred is subject to a claim for overpayment as set out in rule 5160:1-2-04 of the Administrative Code:

(i) An existing claim shall not be transferred. The records transferred to the CDJFS in the county of new residence shall include copies of the documentation of the claim. The CDJFS that established the claim remains responsible for any necessary action on the claim.

(ii) When no claim has been established and the CDJFS in each county agrees the CDJFS in the county of new residence shall establish the claim, then a potential claim may be transferred to the CDJFS in the county of new residence to be established by the CDJFS in that county.

(P) When mail is returned indicating whereabouts unknown, the individual shall still be considered a resident of the state and medical assistance will not be discontinued.

(Q) Distribution of informational materials. The administrative agency:

(1) Shall distribute the internal revenue service (IRS) form 1095-B "Health Coverage" to individuals

in January of each calendar year and upon an individual's request in accordance with the Patient Protection and Affordable Care Act (ACA) (Pub. L. No. 111-148).

(2) Shall distribute voter information and registration materials to individuals in accordance with 42 C.F.R. 431.307 (as in effect October 1, 2022).

(3) May distribute materials directly related to the health and welfare of individuals eligible for medical assistance, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

(R) The administrative agency shall provide timely and adequate written notice of any decision affecting an individual's eligibility, including an approval, denial, discontinuance, or suspension of eligibility, or a denial or change in benefits, consistent with 42 C.F.R. 435.917 (as in effect October 1, 2022) and division 5101:6 of the Administrative Code.