Modified Adjusted Gross Income (MAGI) Medicaid Tax Information Worksheet

- Please complete the information below as it pertains to your household and your Federal Tax filing information.
- This information is **necessary to determine your eligibility** for MAGI Medicaid under the Affordable Care Act and Ohio Medicaid Expansion.

Case Name:				**Case #:**		
Enter Household Member Names:	**Person 1**	**Person 2**	**Person 3**	**Person 4**	**Person 5**	**Person 6**
A. Does this person expect to file taxes?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If the answer to Line A. was YES, complete Lines B. through D. for each person listed.						
B. How will you file?	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate
C. Who do you claim as a dependent, if any?						
D. Does anyone claim YOU as a dependent?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If the answer to Line D. was NO, complete Lines E. through G. for each person listed.						
E. Will you be claimed as a dependent?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
F. By whom?						
G. Do you have 3rd Party Insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If the answer to Line G. was YES, complete Lines H. through I. for each person listed.						
H. Insurance Company:						
I. Type of Coverage:						