Ohio Department of Health

Children with Medical Handicaps Program (CMH)
CMH Financial Application

Section A: Parent/Guardian Information

First Name of Parent/Guardian/Client (18 years or older):	Middle Initial:	Last Name:

Relationship to Client:

Street Address:	City:	State:	Zip:	County:

Home Phone:	Work Phone:	Mobile Phone:

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Re-married ☐ Separated ☐ Natural Parents Residing Together ☐ Single ☐ Other

Currently Pregnant: ☐ Yes ■ No Due Date: ____/____/______ Number of unborn children? ____________________

Section B: Household Information (Please list each person living with you)

Full Name (First, MI, Last):			Date of Birth: ____/____/______	Pregnant: ☐ Yes ☐ No
Ohio Resident: ☐ Yes ☐ No	Social Security #:	Relationship to Client:	☐ Female ☐ Male	Due Date: ____/____/______
CMH Client: ☐ Yes ☐ No	CMH Client Number:	Primary Language:		Number of unborn children: ____________________

Full Name (First, MI, Last):			Date of Birth: ____/____/______	Pregnant: ☐ Yes ☐ No
Ohio Resident: ☐ Yes ☐ No	Social Security #:	Relationship to Client:	☐ Female ☐ Male	Due Date: ____/____/______
CMH Client: ☐ Yes ☐ No	CMH Client Number:	Primary Language:		Number of unborn children: ____________________

Full Name (First, MI, Last):			Date of Birth: ____/____/______	Pregnant: ☐ Yes ☐ No
Ohio Resident: ☐ Yes ☐ No	Social Security #:	Relationship to Client:	☐ Female ☐ Male	Due Date: ____/____/______
CMH Client: ☐ Yes ☐ No	CMH Client Number:	Primary Language:		Number of unborn children: ____________________

Full Name (First, MI, Last):			Date of Birth: ____/____/______	Pregnant: ☐ Yes ☐ No
Ohio Resident: ☐ Yes ☐ No	Social Security #:	Relationship to Client:	☐ Female ☐ Male	Due Date: ____/____/______
CMH Client: ☐ Yes ☐ No	CMH Client Number:	Primary Language:		Number of unborn children: ____________________

Section C: Income Information

For yourself and each person who lives with you (whether you are applying for health coverage for that person or not), list each form of income, such as: annuities, wages, self-employment, social security, VA pension, workers compensation, spousal support, child support and medical support.
MUST INCLUDE:* *3 current pay stubs with Year-To-Date Gross and a copy of your most recent federal tax return including Schedule 1 (Additional Income & Adjustments to Income), if applicable

Name	Employer or Source of Income	Gross Amount	How often Received

Have you or your spouse changed jobs or been unemployed within the past 12 months? If yes, give reason for unemployment. ☐ Yes ☐ No ☐ Not Applicable
Please list beginning and ending dates of all job/income changes

P.O. Box 1603, Columbus, Ohio 43216-1603
(614) 466-1700 OR 1-800-755-4769
FAX (614) 728-3616 Email: bcmh@odh.ohio.gov

Section D: Does anyone in your household pay for someone to care for your children while you are at work or school?

☐ Yes ☐ No If yes, Please attach verification (receipt, canceled check, letter from provider)	Amount paid per week: $ _____

Section E: New/current insurance information for the client

Name of Insurance Company:		Phone Number:
Name of Insured:	Effective Date: ____/____/_____	Monthly Premium: $
Policy Number:	Group Number:	
Does your plan include prescription benefits: ☐ Yes ☐ No	Does your drug plan require mail order pharmacy: ☐ Yes ☐ No	
Name of company that administers prescription benefits:		
Does client have dental insurance: ☐ Yes ☐ No	Does client have vision insurance: ☐ Yes ☐ No	
Name of company that administers dental benefit:		
Name of company that administers vision benefit:		

Section E2: Secondary Insurance information for the client

Name of Insurance Company:		Phone Number:
Name of Insured:	Effective Date: ____/____/_____	Monthly Premium: $
Policy Number:	Group Number:	
Does your plan include prescription benefits: ☐ Yes ☐ No	Does your drug plan require mail order pharmacy: ☐ Yes ☐ No	
Name of company that administers prescription benefits:		
Does client have dental insurance: ☐ Yes ☐ No	Does client have vision insurance: ☐ Yes ☐ No	
Name of company that administers dental benefit:		
Name of company that administers vision benefit:		

Section F: Release of Information and Consent

I hereby authorize my child's/my managing physician or service coordinator to submit this application to the Ohio Department of Health, Children with Medical Handicaps Program, (herein after referred to as "CMH"), for services for the child or client (hereafter referred to as "client") named on the front of this application. I authorize CMH to release confidential information concerning the client's medical condition and treatment, all financial information and third-party coverage to county and/or city health departments located in the city or county where the client lives or receives treatment and to health care and service providers, facilities and third-party payors (and their agents and employees) for the purpose of providing or facilitating the delivery of or arranging for services to the client. This authorization includes the release of all information concerning the client's medical conditions and treatment, including if applicable, the client's HIV testing or diagnosis of AIDS or AIDS-related conditions.

I certify and attest that all the information given by me on this form and other CMH application forms is true and accurate. I hereby give my permission to have all financial information verified. I authorize the release to CMH of all information pertaining to my contract of insurance as to claims filed on behalf of client and amounts paid and to whom these claims or amounts were paid.

The release authorization is effective from the date of my signature and will remain in effect until I expressly revoke it in writing. I understand that the above-referenced information will not be released to any other entity without an additional written release authorization from me or other person having legal authority to provide such release or as required by law. I have read this authorization to release information and fully understand its contents and acknowledge receipt of the CMH Health Insurance Portability and Accountability Act Privacy Notice.

When a child turns age 18, he/she (if possible) must sign this form. If the 18-year-old is unable to sign, the parent or legal guardian may sign the form and provide a written explanation regarding the reason that the 18-year-old cannot sign, along with court documentation appointing parent as guardian.

I,_____, Give permission to CMH to release information and/or discuss my case with _____
(Client's Name) (Name and Relationship to Client)

_____
Parent/Legal Guardian/Client Signature Relationship to Client Date

Please attach additional sheet if more space is needed.