

Ohio Department of Health
 Bureau for Children with Medical Handicaps
 P.O. Box 1603, Columbus, Ohio 43216-1603
 (614) 466-1700 OR 1-800-755-4769

Release of Information and Consent

Child's/client's name			List all children in home currently involved with BCMH																							
Case number																										
Birth date																										
County of residence																										
U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, please submit a copy of U.S. Immigration Visa, I-94 , or other verification from the Immigration and Naturalization Services (INS) regarding the current residency status for this child/client and his/her parents.																										
Is child residing with parent(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is child/client self-supporting? <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital status of child's parent(s) with custody <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Remarried <input type="checkbox"/> Natural parents residing together																						
If child is not residing with parents, state your relationship to the child. Please submit a copy of guardianship/custody papers.			If this child was adopted, give date adoption became final. Please submit a copy of adoption decree.																							
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Does this child/client receive: <i>(each line must be completed)</i> \$ Amount</th> <th style="text-align: center; border-bottom: 1px solid black;">Date applied</th> <th style="text-align: center; border-bottom: 1px solid black;">Date denied</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;">1. Supplemental Security Income (SSI) <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No <input type="checkbox"/> Denied</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;">2. Social Security Disability Income (SSDI) <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No <input type="checkbox"/> Denied</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;">3. Medicaid Spend down <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No <input type="checkbox"/> Denied</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;">4. Medicaid/Healthy Start <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Denied</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;">5. Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Denied</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;">6. Women, Infants and Children (WIC) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Denied</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> </tbody> </table>						Does this child/client receive: <i>(each line must be completed)</i> \$ Amount	Date applied	Date denied	1. Supplemental Security Income (SSI) <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No <input type="checkbox"/> Denied			2. Social Security Disability Income (SSDI) <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No <input type="checkbox"/> Denied			3. Medicaid Spend down <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No <input type="checkbox"/> Denied			4. Medicaid/Healthy Start <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Denied			5. Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Denied			6. Women, Infants and Children (WIC) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Denied		
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Number of dependents claimed on parent's/client's Federal Income Tax Form		Gross Income of household last year (before taxes) \$ _____		If child/client has Medicaid, what is the billing/recipient number on the child's/client's medical card?																						
Name of Job and Family Services caseworker				Caseworker's phone number ()																						
Who is currently employed? <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Self																										
Name of employer <input type="checkbox"/> father's, <input type="checkbox"/> mother's, <input type="checkbox"/> self			Name of employer <input type="checkbox"/> father's, <input type="checkbox"/> mother's, <input type="checkbox"/> self																							
Employer's address			Employer's address																							
City		State	ZIP	City																						
State		ZIP		State ZIP																						
Work phone number ()			Work phone number ()																							

IMPORTANT—please complete additional information on back

Have you or your spouse changed jobs within the past year? If yes , give reason and give beginning and ending dates of all job changes within the past year. <input type="checkbox"/> Yes <input type="checkbox"/> No _____			
Were you or your spouse unemployed this year or last year? If yes , give reason and give beginning and ending dates of unemployment. <input type="checkbox"/> Yes <input type="checkbox"/> No _____			
If your income this year will be different from last year, give a full explanation. (If you have no income, also explain.) _____			
Health insurance company that covers/client		Telephone number ()	
Policy holder	Policy number	Group number	Effective date
Is this child's/client's coverage limited by a pre-existing clause? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," date clause expires		If this policy has a benefits cap, what is the lifetime maximum \$	
Does this child/client have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Total amount you pay for health insurance per month (including dental and vision) \$	
Secondary health insurance company		Telephone number ()	
Policy holder	Policy number	Group number	Effective date

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, Bureau for Children With Medical Handicaps, (herein after referred to as "BCMh"), for services for the child or client (hereinafter referred to as "client") named on the front of this application

I authorize BCMh to release confidential information concerning the client's medical condition and treatment, any and 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 purposes of providing or facilitating the delivery of or arranging for services to the client. This authorization includes the release of any and 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 BCMh application forms is true and accurate. I hereby give my permission to have all financial information verified. I authorize the release to BCMh of any and 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.

This release authorization is effective from the date of my signature and will remain in effect until such time as 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 BCMh Health Insurance Portability and Accountability Act Privacy Notice.

Parent's/guardian's/client's signature	Date
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The best time of day to contact me by telephone is:

Someone not living with me who will know my address or how to contact me		
Name	Relationship to child	Telephone number ()