Children with Medical Handicaps Program (CMH)
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

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:

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

Full Name (First, MI, Last)			DOB: mm/dd/yyyy	Pregnant? ☐Yes ☐No
Ohio Resident ☐Yes ☐No	Social Security #	Relationship to Client:	Female: ☐ Male: ☐	Due Date: mm/dd/yyyy
CMH Client ☐Yes ☐No	CMH Client Number	Primary Language:		Number of unborn children:

Full Name (First, MI, Last)			DOB: mm/dd/yyyy	Pregnant? ☐Yes ☐No
Ohio Resident ☐Yes ☐No	Social Security #	Relationship to Client:	Female: ☐ Male: ☐	Due Date: mm/dd/yyyy
CMH Client ☐Yes ☐ No	CMH Client Number	Primary Language:		Number of unborn children:

Full Name (First, MI, Last)			DOB: mm/dd/yyyy	Pregnant? ☐Yes ☐No
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Full Name (First, MI, Last)			DOB: mm/dd/yyyy	Pregnant? ☐Yes ☐No
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CMH Client ☐Yes ☐ No	CMH Client Number	Primary Language:		Number of unborn children:

Full Name (First, MI, Last)			DOB: mm/dd/yyyy	Pregnant? ☐Yes ☐No
Ohio Resident: ☐Yes ☐ No	Social Security #	Relationship to Client:	Female: ☐ Male: ☐	Due Date: mm/dd/yyyy
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), 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 all schedules*

Name	Employer or Source of Income	Gross Amount	How often Received

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

Ohio Department of Health

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, cancelled 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: mm/dd/yyyy
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: mm/dd/yyyy
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 (hereinafter 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 purposes 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.

This 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.

I,_____, Give permission to CMH to release information and/or discuss my case with _____

Parent/Legal Guardian/Client Signature:	Relationship to Client:	Date: mm/dd/yyyy

Please attach additional sheet if more space is needed.