THE OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

Healthy Start Healthy Families

COMBINED PROGRAMS APPLICATION

Health Care Coverage for Ohio's Families

Administered by the Ohio Department of Job & Family Services

Healthy Start Healthy Families 1-800-324-8680 OHIO

JFS 07216 (Rev. 10/2006)

HEALTHY FAMILY OPTIONS

Ohio offers families a variety of options for getting health care services. Below is a brief description of four publicly funded programs that are available throughout Ohio. Families can apply for one or all of the following programs by using the attached application.

Healthy Start and Healthy Families

Healthy Start and Healthy Families offer free health coverage to families, children (up to age 19) and pregnant women. Coverage includes: doctor visits, hospital care, pregnancy related services, prescriptions, vision, dental, substance abuse, mental health services and much more! These are important health care services that your family needs to stay healthy and strong. Healthy Start and Healthy Families are Medicaid programs administered by the Ohio Department of Job & Family Services. For more information, please call 1-800-324-8680 or visit www.jfs.ohio.gov/ohp. Those families who are interested in getting cash assistance through Ohio Works First, Food Stamps, or Medicaid for the aged, blind or disabled should contact their local county department of job & family services.

Women, Infants & Children (WIC)

The Women, Infants and Children (WIC) Program provides nutritious foods, important nutrition information, and breast feeding education. It also helps eligible families find a family doctor or any other services they might need. To be eligible for WIC you must be pregnant or breast feeding or have just had a baby. Children from birth to age 5 also qualify. Families must meet WIC program medical or nutritional risk guidelines. To apply, fill out the attached application or visit your local WIC clinic for more information. The WIC program is administered by the Ohio Department of Health (ODH).

It has been proven that families who get regular health check-ups and health care education are less likely to have children who miss school and parents who miss work.

Child & Family Health Services (CFHS)

The Child and Family Health Services (CFHS) Program in your area may provide one or more of the following services: child and adolescent health care, prenatal care, and/or family planning care. All of the clinics offer physicals, nutrition counseling, social services, laboratory tests, health education and more! The cost of the clinic services is based on your family size and income but no one is turned away from services if they cannot pay. To apply, please fill out the attached application or visit your local CFHS. This program is administered by ODH.

Bureau for Children with Medical Handicaps (BCMH)

Bureau for Children with Medical Handicaps (BCMH) is a health care program that provides services for children with special health care needs. To receive BCMH services a child must be an Ohio resident under age 21 and be under the care of a BCMH-approved doctor. Families must also meet income eligibility criteria. BCMH works closely with public health nurses in local health departments to increase services to children with handicaps and their families. To find out more about BCMH, families can contact their local health department or call 1-800-755-GROW (4769).

Those who are interested in getting cash assistance through Ohio Works First, Food Stamps, or Medicaid for the aged, blind or disabled should contact the county department of job & family services.

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COMBINED PROGRAMS APPLICATION

NO FACE-TO-FACE INTERVIEW NECESSARY IF APPLYING FOR ONLY HEALTH COVERAGE

A separate application is required for cash assistance or food stamps.

DIRECTIONS

1. **Fill out the application on pages 1,2 & 3. Use pages 4 & 5 if you need more space.**

2. **Each person applying for health coverage through Healthy Start and Healthy Families must give a social security number OR proof that an application for a social security number has been submitted. A social security number is NOT required if you only want WIC, CFHS, and/or BCMH.**

3. **SIGN & DATE the application on page 3.**

4. **SIGN & DATE "Your Rights & Responsibilities" on page 6.**

5. **Attach copies of important documents. (See page 7 for a full listing.)**

6. **Mail your Application, Rights & Responsibilities and Important Documents to your local county department of job & family services.**

Questions? Need help completing this form?
Call 1-800-324-8680
TDD 1-800-292-3572.

Turn to the next page to start the application

Those who are interested in getting cash assistance through Ohio Works First, or Food Stamps, or Medicaid for the aged, blind, or disabled should contact their local county department of job & family services.

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Section A: What programs would you like to apply for? (Please check.)

☐ Health Coverage (Healthy Start/Expedited Medicaid or Healthy Families) ☐ Child & Family Health Services (CFHS)
☐ Nutritional Program for Women, Infants & Children (WIC) ☐ Children w/ Medical Handicaps (CMH)

First Name of Person Completing Application **Middle Initial** **Last Name**

Street Address Apt. #

City State Zip Code County

Home Telephone
(__ __ __) - __ __ __ - __ __ __ __

Work Telephone
(__ __ __) - __ __ __ - __ __ __ __

Are you applying for Health Coverage through Healthy Start or Healthy Families for yourself? ☐ YES ☐ NO

If YES, provide Social Security # _ _ _ - _ _ - _ _ _ _ Date of Birth _ _ / _ _ / _ _ _ _

If you are applying for Health Coverage, WIC, BCMH, and/or CFHS for yourself, complete the information below.

Relationship to You	ETHNICITY	RACE	PRIMARY LANGUAGE	Are you a U.S. Citizen?	Are you disabled?
SELF SEX ☐ Male ☐ Female	☐ Hispanic/Latino ☐ Not Hispanic/ Latino	☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White	☐ English ☐ Other _____ please list	☐ Yes ☐ No	☐ Yes ☐ No

Are you pregnant? ☐Yes ☐No **If YES, # of Babies Due ____** **Due Date _ _ / _ _ /_ _ _ _**

Section B. **Please list everyone living with you.** A social security number is required for everone who wants health coverage. Use page 4 if you need more space.

Household Member #1

First Name **Middle Initial** **Last Name**

Is this person applying for Health Coverage through Healthy Start and Healthy Families? ☐ Yes ☐No

If YES, provide Social Security # _ _ _ - _ _ - _ _ _ _ Date of Birth _ _ / _ _ / _ _ _ _

If this person is applying for Health Coverage, WIC, BCMH, and/or CFHS, complete the information below.

Relationship to You	ETHNICITY	RACE	PRIMARY LANGUAGE	Is this person a U.S. Citizen?	Is this person disabled?
_____ SEX ☐ Male ☐ Female	☐ Hispanic/Latino ☐ Not Hispanic/ Latino	☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White	☐ English ☐ Other _____ please list	☐ Yes ☐ No	☐ Yes ☐ No

Is this person pregnant? ☐Yes ☐No **If YES, number of Babies Due ____** **Due Date _ _ / _ _ /_ _ _ _**

Household Member #2

First Name **Middle Initial** **Last Name**

Is this person applying for Health Coverage through Healthy Start and Healthy Families? ☐ Yes ☐ No

If YES, provide Social Security # _ _ _ - _ _ - _ _ _ _ Date of Birth _ _ / _ _ / _ _ _ _

If this person is applying for Health Coverage, WIC, BCMH, and/or CFHS, complete the information below.

Relationship to You	ETHNICITY	RACE	PRIMARY LANGUAGE	Is this person a U.S. Citizen?	Is this person disabled?
_____ SEX ☐ Male ☐ Female	☐ Hispanic/Latino ☐ Not Hispanic/ Latino	☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White	☐ English ☐ Other _____ please list	☐ Yes ☐ No	☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐No If YES, number of Babies Due _____ Due Date _ _ / _ _ /_ _ _ _

Household Member #3

First Name **Middle Initial** **Last Name**

Is this person applying for Health Coverage through Healthy Start and Healthy Families? ☐ Yes ☐ No

If YES, provide Social Security # _ _ _ - _ _ - _ _ _ _ Date of Birth _ _ / _ _ / _ _ _ _

If this person is applying for Health Coverage, WIC, BCMH, and/or CFHS, complete the information below.

Relationship to You	ETHNICITY	RACE	PRIMARY LANGUAGE	Is this person a U.S. Citizen?	Is this person disabled?
_____ SEX ☐ Male ☐ Female	☐ Hispanic/Latino ☐ Not Hispanic/ Latino	☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White	☐ English ☐ Other _____ please list	☐ Yes ☐ No	☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐No If YES, number of Babies Due _____ Due Date _ _ / _ _ /_ _ _ _

Need more space? Use page 4 if you have more household members to include on your application.

Section C. INCOME VERIFICATION - Complete the lines below for each person in your household who has earned or unearned income from any source, such as: **wages, self-employment, social security, SSI, VA pension, workers compensation, alimony or child support.** Fill out page 5 if you need more space. (Proof of income is required - See page 7)

Name	Employer or Income Source	Gross Amount	How Often Received
		$	
		$	

Section D. Do you or someone in your household PAY for someone to care for your children while you work or go to school? If YES, how much do you pay per child per week?

☐ Yes ☐ No **$**_____

Section E. Do you or someone in your household PAY child support? If YES, how much do you pay per week?

☐ Yes ☐ No **$**_____

Section F. **OTHER HEALTH INSURANCE** - For each person in your household who has health insurance or a medical support order, please complete the lines below. Fill out page 5 if additional space is needed. (Proof of health insurance is required - See page 6)

Insurance Company	Policy Number	Monthly Premium	Persons Covered	Please **CIRCLE** the services each policy covers.
		$		Inpatient Hospital Doctor Visits Prescriptions Ambulance Dental Vision
		$		Inpatient Hospital Doctor Visits Prescriptions Ambulance Dental Vision

Section G. Would you like your eligibility for medical coverage looked at for the past 3 months? If YES, include income verification & medical expenses for each of the past 3 months. If you are found eligible, Medicaid may pay some or all of these medical expenses. ☐Yes ☐No

Section H. Would you like to get information on any of the following programs? (Please check.) The County Department of Job & Family Services (CDJFS) will contact you to help you apply.
☐Child Care ☐Child Support ☐Cash Assistance ☐Food Stamps

BY SIGNING THIS APPLICATION, I AGREE to give documentation and verification of information on this application. I understand I may be asked to give consent to the CDJFS to make whatever contacts are necessary to determine my eligibility. I authorize any person who furnishes health care or medical supplies to give the Ohio Department of Job & Family Services or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Healthy Start, Healthy Families Medicaid program, WIC and medical assistance programs. I also authorize the Ohio Department of Health and the Ohio Department of Job & Family Services to exchange any information I have provided on this form, in order to enable the departments to determine my eligibility. I understand that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

NOTE: Your Social Security Number (SSN) is not needed if you only want to get WIC, CFHS, and CMH Programs. But, if you give the SSN on this application, it will be used for program reviews. These reviews tell the agency if program participation and outreach are taking place.

By my signature below, I affirm that to the best of my knowledge and belief the answers on this application are complete and correct. I understand that the law provides a penalty of fine or imprisonment (or both) for anyone convicted of accepting assistance he or she is not eligible for. I state under penalty of perjury that all of the information on this application is true and complete to the best of my knowledge.

SIGNATURES

_____ Person Applying Date: _ _/ _ _/ _ _ _ _

_____ Person Who Helped Complete This Form or Authorized Representative Date: _ _/ _ _/ _ _ _ _

Mailing Address **(if different than address in Section A)**

_____
Street Address Apt. #

_____ _____ _____ _____
City State Zip Code County

Home Telephone
(_ _ _) - _ _ _ - _ _ _ _

Work Telephone
(_ _ _) - _ _ _ - _ _ _ _

PLEASE MAIL COMPLETED APPLICATION, RIGHTS & RESPONSIBILITIES AND COPIES OF IMPORTANT INFORMATION TO: THE COUNTY DEPARTMENT OF JOB & FAMILY SERVICES (CDJFS)

For help completing this form or for CDJFS address information, call 1-800-324-8680 (TDD 1-800-292-3572 for hearing impaired persons.)

GOT MORE INFO? HERE'S MORE SPACE...

(Continued from Section B) Pages 4 & 5 can be used if you have more household members to include on your application. Please fill out the following sections for additional household members, income verification and/or health insurance information.

Household Member #4

First Name **Middle Initial** **Last Name**

Is this person applying for Health Coverage through Healthy Start and Healthy Families? ☐ Yes ☐ No

If YES, provide Social Security # _ _ _ - _ _ - _ _ _ _ Date of Birth _ _ / _ _ / _ _ _ _

If this person is applying for Health Coverage, WIC, BCMH, and/or CFHS, complete the information below.

Relationship to You	ETHNICITY	RACE	PRIMARY LANGUAGE	Is this person a U.S. Citizen?	Is this person disabled?
_____ SEX ☐ Male ☐ Female	☐ Hispanic/Latino ☐ Not Hispanic/ Latino	☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White	☐ English ☐ Other _____ please list	☐ Yes ☐ No	☐ Yes ☐ No

Is this person pregnant? ☐Yes ☐ No If YES, number of Babies Due ____ Due Date _ _ / _ _ /_ _ _ _

Household Member #5

First Name **Middle Initial** **Last Name**

Is this person applying for Health Coverage through Healthy Start and Healthy Families? ☐Yes ☐ No

If YES, provide Social Security # _ _ _ - _ _ - _ _ _ _ Date of Birth _ _ / _ _ / _ _ _ _

If this person is applying for Health Coverage, WIC, BCMH, and/or CFHS, complete the information below.

Relationship to You	ETHNICITY	RACE	PRIMARY LANGUAGE	Is this person a U.S. Citizen?	Is this person disabled?
_____ SEX ☐ Male ☐ Female	☐ Hispanic/Latino ☐ Not Hispanic/ Latino	☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White	☐ English ☐ Other _____ please list	☐ Yes ☐ No	☐ Yes ☐ No

Is this person pregnant? ☐Yes ☐No If YES, number of Babies Due ____ Due Date _ _ / _ _ /_ _ _ _

ADDITIONAL SPACE CONTINUED...

Please fill out the information below if you need more space for income verification and/or health insurance information.

Additional Section for Income Verification (Continued From Section C)

Name	Employer or Income Source	Gross Amount	How Often Received
		$	
		$	
		$	
		$	
		$	
		$	

Additional Section for Other Health Insurance (Continued from Section F)

Insurance Company / Policy Number	Monthly Premium	Persons Covered	Please **CIRCLE** the services each policy covers.
	$		Inpatient Hospital Doctor Visits Prescriptions Ambulance Dental Vision
	$		Inpatient Hospital Doctor Visits Prescriptions Ambulance Dental Vision
	$		Inpatient Hospital Doctor Visits Prescriptions Ambulance Dental Vision
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Healthy Start Healthy Families 1-800-324-8680

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Read, Sign & Return this Page!

(with your application)

YOUR RIGHTS & RESPONSIBILITIES

The Ohio Department of Job & Family Service (ODJFS) assures that no person seeking participation in any program or person currently participating in a program shall have services denied / delayed or otherwise be discriminated against on the basis of race, color, religion, sex, national origin, disability, age, veteran status or sexual orientation.

YOU HAVE A RIGHT TO A STATE HEARING before the ODJFS if you are not satisfied with actions taken or decisions on your application. *When the county department of job & family services receives your application, you will get a form that tells you how to ask for a hearing.*

YOU HAVE A RESPONSIBILITY:

TO REPORT CORRECT AND UPDATED INFORMATION. You are always responsible for giving complete and correct information about yourself and members of your household. You must include all supporting documentation and verifications with your completed application. You must report to the county department of job & family services, within 10 days, any change in your circumstances, such as: •You move to another address •Someone moves in with you or moves out •Any household member's income changes • A household member gets or loses a job •A child drops out of school or reaches the age of 19 •The end of your pregnancy and / or the birth of your child(ren).You should also report if anyone in your household, (including children) becomes disabled, is unable to work, or has applied for disability benefits (e.g., Social Security Disability, SSI, Workers Compensation, veteran's benefits.) You should report this information as soon as you become aware of it because it may help the person stay eligible for Medicaid benefits.

TO PROVIDE PROOF OF U.S CITIZENSHIP/ALIEN STATUS. If you or members of your family are applying for Healthy Start, Healthy Families (Medicaid), you must provide the county department of job & family services with verification of U.S. citizenship for each person you are applying for. Family members who are not U.S. citizens must provide the county department of job & family services with proof of alien status such as an alien registration card or re-entry permit. If you are applying for Healthy Start (Medicaid) for a child, but not for yourself, you are not required to give proof of your own citizenship.

TO COOPERATE WITH ESTABLISHING PATERNITY AND THIRD PARTY MEDICAL SUPPORT. You must agree to help establish paternity (who the legal father is) for each child who gets assistance from Medicaid, and you must include medical support payments in the child support order.

TO GIVE MEDICAID ANY PAYMENTS YOU RECEIVE FROM OTHER HEALTH INSURANCE. You must tell the county department of job & family services about any other medical coverage you have or if someone else is legally responsible for paying medical bills for you or members of your family. Medicaid does not pay medical bills that a private health insurance company is supposed to pay. When you accept assistance from Medicaid, you must agree to give the ODJFS your right to medical payments from a private medical insurance company while you have Medicaid. If you receive money directly from your medical insurance company to cover medical bills that Medicaid has paid for you or for anyone for whom you are legally responsible for, the ODJFS has the right to get that money back from you.

TO COOPERATE WITH QUALITY CONTROL REVIEWS. Your name may be picked from a list of all the eligible cases in Ohio to see if you really are eligible for assistance based on the information you gave the ODJFS. If your case is picked, you must cooperate by answering all the questions in order to continue to get medical coverage.

RELEASE OF INFORMATION ON SOCIAL SECURITY NUMBER FOR MEDICAID. You must give the county department of job & family services your Social Security Number (SSN) or apply for a SSN for each person seeking medical coverage. If you are applying for Medicaid for a child, you are not required to provide your own SSN, but we must have the child's SSN in order for the child to receive Medicaid. If you are applying for Medicaid for yourself, you must provide your SSN. The agency will use the SSN to verify income, eligibility, and the amount of medical assistance payments we will make on your behalf. Your SSN may also be matched with the records in other agencies such as the Social Security Administration. These matches may be done by computer or on an individual basis. Your social security number is given to medical insurance companies to see if there is coverage to pay all or part of your medical bills. Your social security number will be used during program reviews to make sure you are eligible for this program.

SIGNATURES:

I received a copy of and I have read all my rights and responsibilities or they have been read to me, and I understand them.

Applicant	Date
Authorized Representative or Person Who Helped Complete the Form	Date
If an "X" is used, Signature of One Witness is Needed	Date

Don’t forget to include:

In order to get health care services, there are certain pieces of information you must provide.

APPLICATION CHECKLIST

✓ Proof of Income from work or wages

- ☐ Copies of pay stubs for the previous month, or most recent four week period; **OR**
- ☐ A letter from your employer stating the amount of your monthly gross income; **OR**
- ☐ If self-employed, IRS 1040 tax form with schedule C or F.

✓ Proof of pregnancy (if applicable)

A written statement from a doctor or nurse. This should include the expected date of birth and number of unborn babies (For example: twins = 2 babies).

✓ Proof of U.S. Citizenship or Immigration Documents

If you or someone in your household is applying for Healthy Start, Healthy Families or the Children with Medical Handicaps Programs, you will need to show proof of U.S. citizenship or alien status.

✓ Other Health Insurance

If you or your children have medical coverage through any other health insurance plan, you will need to send in a copy of your insurance card or other proof of coverage. (Please be sure to copy both sides of your card!)

✓ Signed Application

Don’t forget to sign and date your application!

✓ Rights & Responsibilities

Review, sign, date and return with your application!

MAIL APPLICATION & COPIES OF IMPORTANT INFORMATION TO YOUR LOCAL COUNTY DEPARTMENT OF JOB & FAMILY SERVICES.

IF YOU WANT HEALTH COVERAGE THROUGH HEALTHY START AND HEALTHY FAMILIES FOR YOURSELF OR YOUR CHILDREN, YOU MAY BE ASKED TO NAME THE NON-CUSTODIAL PARENT OF YOUR CHILDREN TO HELP GET MEDICAL SUPPORT. IF YOU ARE ASKED FOR THE NON-CUSTODIAL PARENT’S NAME AND DO NOT HELP, YOU MAY LOSE HEALTH COVERAGE FOR YOURSELF. BUT, YOUR CHILDREN WILL STILL BE COVERED UNDER HEALTHY START AND HEALTHY FAMILIES IF YOU MEET THE ELIGIBILITY REQUIREMENTS.

Keep this page !

For Your Records

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Authorized Representative or Person Who Helped Complete the Form	Date
If an "X" is used, Signature of One Witness is Needed	Date

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1-800-324-8680

TDD 1-800-292-3572

or

your local county department of job & family services

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