

PLEASE PRINT

# Ohio Department of Health Medical Application

Bureau for Children With Medical Handicaps, 246 North High Street, P.O. Box 1603, Columbus, Ohio 43216-1603

Diagnostic     Treatment     Case Renewal     Service Coordination     PHN Referral     Adult Hemophilia     HMG

*1. Child's/Client's name (last, first, mi)		2. Case number (child's/client's)	
*3. Address		*4. County	
City		*State	*ZIP
Health department code			
*5. Child's/Client's birthdate	*6. Social Security number (child's/client's)	*7. Sex <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female	*8. Ethnic group
		9. Ohio resident <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	
*10. Parent's/Legal guardian's/Client's name (last, first)		*15. Parent's/Legal guardian's/Client's name (last, first)	
*11. Address		*16. Address	
*City	*State	*ZIP	
*City	*State	*ZIP	
*12. Social Security number		*17. Social Security number	
*13. Home phone (    )	*14. Work phone (    )	*18. Home phone (    )	*19. Work phone (    )

### Insurance Information

For BCMH USE ONLY

*20. Health insurance coverage <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	Policy number	Begin date	End date	Carrier number
Health insurance company name		Name of insured		
*21. Health insurance coverage <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	Policy number	Begin date	End date	Carrier number
Health insurance company name		Name of insured		
22. Dental insurance coverage <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	Carrier number	Begin date	End date	
Dental insurance company name		Name of insured		
23. Vision care insurance coverage <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	Carrier number	Begin date	End date	
Vision care insurance company name		Name of insured		
*24. Medicaid eligible <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	*Medicaid recipient/Billing number	Begin date	End date	25. S.S.I. eligible <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No

*26. Managing physician's/Service coordinator's name			Site <input type="checkbox"/> Private office <input type="checkbox"/> Clinic	
*27. Address			28. Telephone number (    )	
*City	*State	*ZIP	*29. Provider number	
*30. Primary diagnosis	*I.C.D. code	*31. Secondary diagnosis	*I.C.D. code	
*32. Tertiary diagnosis	*I.C.D. code	*33. Quaternary diagnosis	*I.C.D. code	

\*DATA REQUIRED IN ORDER TO PROCESS

Child's/Clients name		Case number
34. If child/client has any other handicapping condition(s), please describe _____ _____		
35. Name of primary care physician	36. Name of primary care dentist	

### 37. Major Services

Category of service	Name and address of provider	Provider number	Unit of service	Source of payments

38. Recommendations (Include/attach Plan of Treatment, Medical Report and/or Discharge Summary.)		
*39. Managing physician's/Service coordinator's signature	*Date	*40. Initial date of exam
*Print physician's name		
41. Name of person completing form	Telephone (      )	*42. Most recent date of exam

### Public Health Nurse Referral

43. Name	44. Health department	45. Telephone (      )
46. Reason		Date of scheduled exam

I hereby authorize the managing physician or service coordinator listed above to submit this application to the Ohio Department of Health, Bureau for Children with Medical Handicaps (hereinafter referred to as "BCM"), for services for the child/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.

*47. Parent's/Guardian's/Client's signature	*Date
*Print name	*Relationship to child/client

48. Approved <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	49. Program	Code	50. Effective date	51. Expiration date
52. Denial reason	Code	53. Denial reason	Code	
54. Nurse case manager				Date

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**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 <b>current</b> 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.	
Does this child/client receive: <i>(each line must be completed)</i> \$ Amount			
		<b>Date applied</b>	<b>Date denied</b>
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 Spenddown	<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		
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	
Work phone number (       )		Work phone number (       )	

**IMPORTANT—please complete additional information on back**

Have you or your spouse changed jobs within the last 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 <hr/>			
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 <hr/>			
If your income this year will be different from last year, give a full explanation. (If you have no income, also explain.) <hr/>			
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 HIPAA 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:
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Someone not living with me who will know my address or how to contact me		
Name	Relationship to child	Telephone number (       )