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?

☐ Yes ☐ 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)?	Is child/client self-supporting?	Marital status of child's parent(s) with custody
☐ Yes ☐ No	☐ Yes ☐ No	☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐ Remarried ☐ 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: *(each line must be completed)* **$ Amount**				**Date applied**	**Date denied**
1. Supplemental Security Income (SSI)	☐ Yes $_____	☐ No	☐ Denied		
2. Social Security Disability Income (SSDI)	☐ Yes $_____	☐ No	☐ Denied		
3. Medicaid Spend down	☐ Yes $_____	☐ No	☐ Denied		
4. Medicaid/Healthy Start	☐ Yes	☐ No	☐ Denied		
5. Medicare	☐ Yes	☐ No	☐ Denied		
6. Women, Infants and Children (WIC)	☐ Yes	☐ No	☐ 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?

☐ Father ☐ Mother ☐ Self

Name of employer ☐ father's, ☐ mother's, ☐ self	Name of employer ☐ father's, ☐ mother's, ☐ 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 past year? **If yes,** give reason and give beginning and ending dates of all job changes within the past year.

☐ Yes ☐ No

Were you or your spouse unemployed this year or last year? **If yes,** give reason and give beginning and ending dates of unemployment.

☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No	Vision Insurance? ☐ Yes ☐ 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

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 ( )