

## Ohio Department of Health

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

# Release of Information and Consent

(for 18 years of age and older)

Client's name			List all children in home currently involved with CMH																																					
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 client and his/her parents.																																								
Is client residing with parent(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is client self-supporting? <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital status of client's parent(s) with custody <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Other <input type="checkbox"/> Divorced <input type="checkbox"/> Remarried <input type="checkbox"/> Natural parents residing together																																				
If client is not residing with parents, state your relationship to the client. Please submit a copy of guardianship/custody papers.			If this client 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="width: 60%;"></th> <th style="width: 10%; text-align: center;">\$ Amount</th> <th style="width: 10%;"></th> <th style="width: 10%; text-align: center;">Date applied</th> <th style="width: 10%; text-align: center;">Date denied</th> </tr> </thead> <tbody> <tr> <td>1. Supplemental Security Income (SSI)   <input type="checkbox"/> Yes \$ _____   <input type="checkbox"/> No   <input type="checkbox"/> Denied</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2. Social Security Disability Income (SSDI)   <input type="checkbox"/> Yes \$ _____   <input type="checkbox"/> No   <input type="checkbox"/> Denied</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3. Medicaid Spend Down   <input type="checkbox"/> Yes \$ _____   <input type="checkbox"/> No   <input type="checkbox"/> Denied</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4. Medicaid/Healthy Start   <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Denied</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>5. Medicare   <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Denied</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6. Women, Infants and Children (WIC)   <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Denied</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>							\$ 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 client has Medicaid, what is the billing/recipient number on the client's medical card?																																				
Name of Job and Family Services caseworker				Caseworker's phone number (       )       )																																				
Who is currently employed? <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			Name of employer <input type="checkbox"/> father(s), <input type="checkbox"/> mother(s), <input type="checkbox"/> self																																					
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City		State	ZIP	City																																				
Work phone number (       )       )		Work phone number (       )       )																																						

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

