

# 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:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Re-married <input type="checkbox"/> Separated <input type="checkbox"/> Natural Parents Residing Together <input type="checkbox"/> Single <input type="checkbox"/> Other					
Currently Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date: ___/___/___ Number of unborn children? _____					

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

Full Name (First, MI, Last):			Date of Birth: ___/___/___	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Ohio Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security #:	Relationship to Client:		<input type="checkbox"/> Female <input type="checkbox"/> Male
CMH Client: <input type="checkbox"/> Yes <input type="checkbox"/> No	CMH Client Number:	Primary Language:		
			Due Date: ___/___/___	Number of unborn children: _____
Full Name (First, MI, Last):			Date of Birth: ___/___/___	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Ohio Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security #:	Relationship to Client:		<input type="checkbox"/> Female <input type="checkbox"/> Male
CMH Client: <input type="checkbox"/> Yes <input type="checkbox"/> No	CMH Client Number:	Primary Language:		
			Due Date: ___/___/___	Number of unborn children: _____
Full Name (First, MI, Last):			Date of Birth: ___/___/___	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Ohio Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security #:	Relationship to Client:		<input type="checkbox"/> Female <input type="checkbox"/> Male
CMH Client: <input type="checkbox"/> Yes <input type="checkbox"/> No	CMH Client Number:	Primary Language:		
			Due Date: ___/___/___	Number of unborn children: _____
Full Name (First, MI, Last):			Date of Birth: ___/___/___	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Ohio Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security #:	Relationship to Client:		<input type="checkbox"/> Female <input type="checkbox"/> Male
CMH Client: <input type="checkbox"/> Yes <input type="checkbox"/> No	CMH Client Number:	Primary Language:		
			Due Date: ___/___/___	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 or not), 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 Schedule 1 (Additional Income & Adjustments to Income), if applicable

Name	Employer or Source of Income	Gross Amount	How often Received

**Section D: Does anyone in your household pay for someone to care for your children while you are at work or school?**

<input type="checkbox"/> Yes <input type="checkbox"/> No <span style="color: red; font-size: small;">If yes, Please attach verification (receipt, canceled check, letter from provider)</span>	Amount paid per week: \$ _____
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**Section E: New/current insurance information for the client**

Name of Insurance Company:		Phone Number:	
Name of Insured:	Effective Date: ____/____/____	Monthly Premium: \$	
Policy Number:	Group Number:		
Does your plan include prescription benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your drug plan require mail order pharmacy: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of company that administers prescription benefits:			
Does client have dental insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Does client have vision insurance: <input type="checkbox"/> Yes <input type="checkbox"/> 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: ____/____/____	Monthly Premium: \$	
Policy Number:	Group Number:		
Does your plan include prescription benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your drug plan require mail order pharmacy: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of company that administers prescription benefits:			
Does client have dental insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Does client have vision insurance: <input type="checkbox"/> Yes <input type="checkbox"/> 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, Complex Medical Help Program, (herein after referred to as "CMH"), for services for the child or client (hereafter 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 purpose 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.

The 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, along with court documentation appointing parent as guardian.

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

(Client's Name) (Name and Relationship to Client)

\_\_\_\_\_

Parent/Legal Guardian/Client Signature Relationship to Client Date

Please attach additional sheet if more space is needed.