Reset Form

Ohio Department of Job and Family Services

The Child Care/Healthy Start and Healthy Families Supplement

*This form is valid only when attached to a JFS 01138 Child Care Application

A. PRIMARY LANGUAGE/LANGUAGE PREFERENCE: _____

B. I would also like to be referred to the following programs: (Please check.)

☐ Child and Family Health Services (CFHS) ☐ Children with Medical Handicaps (BCMH)

☐ Nutritional Program for Women, Infants and Children (WIC)

C. List the name(s) of anyone in your family who is pregnant and is applying for health care coverage. **Attach proof of pregnancy** for that individual – a written, signed statement from a doctor or nurse which includes the expected date of birth and number of unborn babies.

Name: _____ Name: _____

Name: _____ Name: _____

D. INCOME VERIFICATION – List any income for a member of your family which is not already listed on the child care application such as **VA pension or SSI.** You must include verification of all income with this application.

Name: _____ Type of Income: _____ Gross Amount $ _____ per month

E. Do you or another member of your family currently **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**?

☐No ☐Yes $_____ per week

If child care is not subsidized provide a receipt or signed statement from your child care provider explaining the amount paid and how often it is paid.

F. OTHER HEALTH INSURANCE – For every person in your family who has health insurance or a medical support order, please complete the lines below. (You must attach a copy of your medical insurance card both front and back.)

Name of Policy Holder	Insurance Company	Policy Number	Monthly Premium	Persons Covered	Select the service that each policy covers		
					☐ Dental ☐ Vision	☐ Doctor Visits ☐ Prescriptions	☐ Inpatient Hospital ☐ Outpatient Hospital
					☐ Dental ☐ Vision	☐ Doctor Visits ☐ Prescriptions	☐ Inpatient Hospital ☐ Outpatient Hospital

G. Does anyone in your family have **UNPAID** medical bills for services rendered in the last three months? If **YES**, attach copies of the medical bills (make sure that the bill shows a service date) and four weeks of income verification for each month in which there are bills. For example, if you return this application in June and have unpaid medical bills from April, please provide copies of those bills and verification of all income received in April (pay stubs, child support check stubs, etc.). If you are found eligible, Medicaid may pay some or all of these expenses.

☐ **No** ☐ **Yes** Please list the months in which you have UNPAID bills: _____, 20___

_____, 20___

_____, 20___

BY SIGNING THIS APPLICATION, I AGREE to give documentation and verification of information on this application. I understand that I may be asked to give consent to the CDJFS to make whatever contacts are necessary to determine my eligibility. 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.

Each individual applying for Medicaid shall provide proof of U.S. citizenship. Individuals are not required to provide proof of U.S. citizenship or immigration status when they are not applying for Medicaid themselves. Individuals applying for Alien Emergency Medical Assistance (AEMA) are not required to provide proof of immigration status.

SIGNATURES: I have read all of my rights and responsibilities (on the reverse side) or they have been read to me and I understand them.

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

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 and family services for information on how to apply. There are separate requirements for these programs, including a face-to-face interview.

YOUR RIGHTS AND RESPONSIBILITIES

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 Ohio Department of Job and Family Services (ODJFS) if you are not satisfied with actions taken or decisions made on your application. For example: if your application is denied but you believe you are eligible; if you do not agree with the type or amount of your benefits; or if you are not told in writing the reason your benefits are to change. *When the county department of job and family services receives your application, you will get a form that tells you how to ask for a hearing.*

YOU HAVE A RIGHT TO AN INFORMAL CONFERENCE WITH YOUR COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES. If a mistake has been made, it can be corrected. If you are not satisfied with the result of your county conference, you can still have a state 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 and 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 of the home ✦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) ✦Any change in marital status ✦Relocation to another county.

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, Social Security Income, 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 INFORMATION REGARDING U.S. CITIZENSHIP/IMMIGRATION STATUS if you or your family are applying for Healthy Start or Healthy Families Medicaid. Family members who are not U.S. citizens must provide the county department of job and family services with proof of U.S. citizenship or immigration status. If you are applying for Healthy Start (Medicaid) for a child, but not for yourself, you are not required to supply proof about your U.S. citizenship or your immigration status.

TO GIVE MEDICAID ANY PAYMENTS YOU RECEIVE FROM OTHER HEALTH INSURANCE. You **must** tell the county department of job and 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 Ohio Department of Job and Family services 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, the Ohio Department of Job and Family Services has the right to get that money back from you.

TO COOPERATE WITH QUALITY CONTROL REVIEWS. Your name may be selected from a list of all the eligible cases in Ohio to verify your eligibility for assistance based on the information you gave the Ohio Department of Job and Family Services. If your case is selected, you must cooperate by answering all the questions in order to continue to receive medical coverage.

RELEASE OF INFORMATION ON SOCIAL SECURITY NUMBER FOR MEDICAID. You **must** give the county department of job and family services your Social Security Number (SSN) or apply for a SSN for each person seeking medical coverage. If you are only 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 SSN is given to medical insurance companies to see if there is coverage to pay all or part of your medical bills. Your SSN will be used during program reviews to verify your eligibility.

PLEASE READ: I received a copy of and I have read my rights and responsibilities and I understand them. I agree to fulfill my responsibilities as described. I give my consent to the agency to make whatever contacts are necessary to determine my eligibility for assistance and to verify information I have given in this application. I agree to provide proof if such proof is requested. I have received a complete explanation regarding the requirements for determining eligibility, the reasons why I may not be eligible, my responsibility for reporting changes to the county department of job and family services, and the penalty, including possible civil action or criminal prosecution, for the intentional withholding of information. 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 penalty of fine or imprisonment (or both) for anyone convicted of accepting assistance for which he or she is not eligible.** I state under penalty of perjury that all information is true and complete to the best of my knowledge.

PLEASE MAKE SURE TO SIGN THE FRONT OF THIS FORM WHERE INDICATED. THE APPLICATION IS NOT VALID WITHOUT A SIGNATURE.