Reset Form

Ohio Department of Job and Family Services

COMBINED PROGRAMS APPLICATION

Information and instructions begin on page 3.

VOTER REGISTRATION APPLICATION ATTACHED - ASSISTANCE AVAILABLE

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ YES, I want to register to vote. ☐ NO, I do not want to register to vote.

If you do not check either box, you will be considered to have decided not to register to vote at this time.

Section A. For which programs would you like to apply? ***(Please check.)*** **For information about these programs, please see page 4.**

☐ Healthy Start and Healthy Families (Medicaid) ☐ Child & Family Health Services (CFHS) ☐ Help Me Grow (HMG)

☐ Nutritional Program for Women, Infants & Children (WIC) ☐ Bureau for Children w/ Medical Handicaps (BCMH)

Section B. Would you like information on any of the following programs? *(Please check.)* The County Department of Job & Family Services (CDJFS) will contact you to help you apply. ☐ Child Care ☐ Child Support ☐ Cash Assistance ☐ Food Assistance

Section C. Has anyone applying for Medicaid received medical care in the past 3 months? ☐ Yes ☐ No If YES, include income verification & medical expenses for each of the past 3 months.

If you are under 21, were you in foster care on your 18th birthday? ☐ Yes ☐ No

First name ***of person applying***	MI	Last Name	Home Phone	Work Phone

Street Address *(including apartment number)*	City	State	Zip	County

Section D. Please name each person living with you. For each person, **answer the rest of the questions only if you are applying for health coverage for that person. If you are applying for health coverage for yourself,** please list yourself as the first person.

1. Full Name *(First, MI, Last)*	Relationship to you	Hispanic/ Latino?	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White	Primary language ☐ English ☐ Other *(Please specify)*	U.S. Citizen? ☐ Yes ☐ No	If pregnant: # of unborn babies
DOB / Social Security #	☐ Female ☐ Male	☐ Yes ☐ No			Disabled? ☐ Yes ☐ No	Due date
2. Full Name *(First, MI, Last)*	Relationship to you	Hispanic/ Latino?	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White	Primary language ☐ English ☐ Other *(Please specify)*	U.S. Citizen? ☐ Yes ☐ No	If pregnant: # of unborn babies
DOB / Social Security #	☐ Female ☐ Male	☐ Yes ☐ No			Disabled? ☐ Yes ☐ No	Due date
3. Full Name *(First, MI, Last)*	Relationship to you	Hispanic/ Latino?	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White	Primary language ☐ English ☐ Other *(Please specify)*	U.S. Citizen? ☐ Yes ☐ No	If pregnant: # of unborn babies
DOB / Social Security #	☐ Female ☐ Male	☐ Yes ☐ No			Disabled? ☐ Yes ☐ No	Due date
4. Full Name *(First, MI, Last)*	Relationship to you	Hispanic/ Latino?	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White	Primary language ☐ English ☐ Other *(Please specify)*	U.S. Citizen? ☐ Yes ☐ No	If pregnant: # of unborn babies
DOB / Social Security #	☐ Female ☐ Male	☐ Yes ☐ No			Disabled? ☐ Yes ☐ No	Due date
5. Full Name *(First, MI, Last)*	Relationship to you	Hispanic/ Latino?	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White	Primary language ☐ English ☐ Other *(Please specify)*	U.S. Citizen? ☐ Yes ☐ No	If pregnant: # of unborn babies
DOB / Social Security #	☐ Female ☐ Male	☐ Yes ☐ No			Disabled? ☐ Yes ☐ No	Due date

Section E. For yourself and each person who lives with you (whether or not you are applying for health coverage for that person), list each form of income, such as: annuities, wages, self-employment, social security, VA pension, workers compensation, spousal support, child support or medical support.

Name	Employer or Source of Income	Gross Amount	How Often Received
		$	
		$	
		$	
		$	
		$	

Section F. Does anyone in your household pay for someone to care for your children while you are at work or school?
☐ Yes ☐ No If yes, how much do you pay per child per week? $_____

Section G. Does anyone in your household pay child support or medical support? ☐ Yes ☐ No
If yes, who? _____ How much per week? $_____

Section H. Complete the lines below for each health insurance policy or medical support order for a person who lives with you.

Who is Covered?	Insurance Company	Policy No.	Monthly Premium	Please CHECK the services the policy covers
			$	☐ Inpatient Hospital ☐ Doctor Visits ☐ Prescriptions ☐ Ambulance ☐ Dental ☐ Vision
			$	☐ Inpatient Hospital ☐ Doctor Visits ☐ Prescriptions ☐ Ambulance ☐ Dental ☐ Vision
			$	☐ Inpatient Hospital ☐ Doctor Visits ☐ Prescriptions ☐ Ambulance ☐ Dental ☐ Vision
			$	☐ Inpatient Hospital ☐ Doctor Visits ☐ Prescriptions ☐ Ambulance ☐ Dental ☐ Vision

BY SIGNING THIS APPLICATION, I AGREE to give documentation and verification of information on this application. I understand I may be asked to give consent to the CDJFS to make whatever contacts are necessary to determine my eligibility. By signing an application for and receiving Medicaid, I am assigning to the State of Ohio any rights to medical support and any rights to payments by a liable third party for medical assistance owed to me or to anyone for whom I am legally responsible during the Medicaid eligibility period.

I authorize any person who furnishes health care or medical supplies to give the Ohio Department of Job & Family Services or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Healthy Start, Healthy Families Medicaid program, WIC and medical assistance programs. I also authorize the Ohio Department of Health and the Ohio Department of Job & Family Services to exchange any information I have provided on this form, to enable the departments to determine my eligibility. I understand that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

NOTE: Your Social Security Number (SSN) is not needed if you only want to get WIC, CFHS, HMG, or BCMH programs. If you give the SSN on this application, it will be used for computer data matches to verify your eligibility and for program reviews. These reviews tell the agency if program participation and outreach are taking place.

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 the law provides a penalty of fines or imprisonment (or both) for anyone convicted of accepting assistance he or she is not eligible to receive. I state under penalty of perjury that I have disclosed all annuities and other similar financial devices in which I or my spouse have any interest. **I state under penalty of perjury that all of the information on this application is true and complete to the best of my knowledge.**

Person Applying *(Please Print Name)*	Signature	Date
Authorized Representative or Person Who Completed Form	Signature	Date

Please mail completed application, signed rights and responsibilities form, and copies of important information to your local County Department of Job & Family Services (CDJFS).
For help completing this form, call 1-800-324-8680 (TDD 1-800-292-3572).

No face-to-face interview is necessary when applying for Medicaid or BCMH.

A different application is required for cash or food assistance. To apply for cash assistance through Ohio Works First, for Food Assistance, or for Medicaid for the aged, blind, or disabled, contact your local County Department of Job & Family Services.

DIRECTIONS

1. Fill out the application on pages 1 & 2. SIGN & DATE the application on page 2.
2. Use your own paper if you need more space to answer any questions, including listing more family members in section D.
3. Each person applying for health coverage through Medicaid must give a social security number OR proof that an application for a social security number has been submitted. A social security number is NOT required if you only want WIC, HMG, CFHS, and/or BCMH.
4. Attach copies of important documents, including as those listed below under "Application Checklist".

Questions? Need help completing this form?
Call 1-800-324-8680
TDD 1-800-292-3572

If you have not been provided with a copy of forms JFS 07236 "Your Rights and Responsibilities as a Consumer of Medicaid Health Coverage" or JFS 07400 "Ohio Medicaid Estate Recovery," please ask for these informational forms from your local CDJFS, call the Consumer Hotline **at 1-800-324-8680 or TDD 1-800-292-3572**, or visit http://www.odjfs.state.oh.us/forms/inter.asp.

APPLICATION CHECKLIST

In order to get health care services, there are certain pieces of information you must provide.

Proof of income such as:
- ☐ A copy of a recent pay stub; OR
- ☐ If self-employed, an IRS 1040 tax form with schedule C or F; OR
- ☐ A letter from your employer stating the amount of your monthly gross income.

If you are pregnant, a written statement from a doctor or nurse. This should include the expected date of birth and number of unborn babies (For example: twins = 2 babies).

You will need to show **proof of U.S. citizenship or alien status** for anyone applying for Medicaid. Original documents must be presented to your CDJFS; copies can only be accepted if they are certified by the agency that issued the document.

If you or your children have medical coverage through any other health insurance plan, you will need to send in a copy of your insurance card or other proof of coverage. Please be sure to copy both sides of your card.

Mail your signed application, signed rights and responsibilities form, and copies of important information to your local County Department of Job & Family Services.

If you are approved for Medicaid for yourself or your children, you may be required to cooperate with the child support enforcement agency (CSEA) in establishing paternity (who the legal father is) or establishing and enforcing a child support order that includes medical support. If you are required to cooperate with the CSEA, a referral will be submitted to the CSEA on your behalf. If you are required to cooperate but refuse to do so, you may lose coverage for yourself. Your children would still be covered. If you are not required to cooperate with the CSEA, you may still request child support services by completing the JFS 07076, "Application for Child Support Services".

HEALTH COVERAGE PROGRAMS

Ohio offers families a variety of options for getting health care services. Below is a brief description of five publicly funded programs that are available throughout Ohio. Families can apply for one or all of the following programs by using the attached application.

Healthy Start and Healthy Families

The Healthy Start and Healthy Families programs offer free or low-cost health coverage to families, children (up to age 19) and pregnant women. Certain young adults meeting specific criteria may be covered up to age 21. Coverage includes: doctor visits, hospital care, pregnancy-related services, prescriptions, vision, dental, substance abuse, mental health services and much more! These are important health care services that your family needs to stay healthy and strong. Healthy Start and Healthy Families are Medicaid programs administered by the Ohio Department of Job & Family Services. For more information, please call 1-800-324-8680 or visit www.jfs.ohio.gov/ohp. Those families who are interested in getting cash assistance through Ohio Works First, Food Assistance, or Medicaid for the aged, blind or disabled should contact their local County Department of Job & Family Services.

Women, Infants & Children (WIC)

The Women, Infants, and Children (WIC) program provides nutritious foods, important nutrition information, and breastfeeding education and support. It also helps eligible families find health care or other services they need. To be eligible for WIC, you must be a woman who is pregnant or breastfeeding or have a baby less than six months old. Children from birth to age 5 also qualify. Families must meet WIC income and medical or nutritional risk guidelines. To apply, complete the attached application or visit your local WIC clinic for more information. The WIC program is administered by the Ohio Department of Health (ODH).

Child & Family Health Services (CFHS)

The Child and Family Health Services (CFHS) Program in your area may provide one or more of the following services: child and adolescent health care, prenatal care, and/or family planning care. They may provide well-child physicals, nutrition counseling, laboratory tests, health education and may be able to help to get other health care you need. If you don't have any other way to pay for services at a CFHS clinic such as health insurance or Medicaid coverage, the cost of clinic services will be based on your family size and income. No one is turned away from services if they cannot pay. To apply, please fill out the attached application or visit your local Child and Family Health Services clinic. This program is administered by ODH.

Bureau for Children with Medical Handicaps (BCMH)

The Bureau for Children with Medical Handicaps (BCMH) is a health care program providing services for children with special health care needs. To receive BCMH services a child must be an Ohio resident under age 21 and be under the care of a BCMH-approved doctor. Families must also meet income eligibility criteria. BCMH works closely with public health nurses in local health departments to increase services to children with handicaps and their families. To find out more about BCMH, families can contact their local health department or call 1-800-755-GROW (4769). This program is administered by ODH.

Help Me Grow (HMG)

The goal of the Help Me Grow program is to assure that newborns, infants and toddlers across Ohio have the best possible start in life. Local Help Me Grow programs provide services that:

- Identifies children with or at risk for developmental delays or disabilities;
- Provides screenings for health, hearing, vision and development;
- Provides parents with information about their child's social and emotional development that lays the foundation for later school success;
- Assures that parents have information on the importance of early childhood immunizations and routine pediatric health care; and
- Connects children at age three with appropriate services.

Those who are interested in getting cash assistance through Ohio Works First, Food Assistance, or Medicaid for the aged, blind or disabled should contact their local County Department of Job & Family Services.

Voter Registration Form

Please read instructions carefully. Please type or print clearly with blue or black ink.
For further information, you may consult the Secretary of State's Web site at: www.sos.state.oh.us or call 1-877-767-6446.

Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of the election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be *received or postmarked* by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice prior to Election Day, please contact your county board of elections.

Lines 1 and 2 below are required by law. You *must* answer ***both*** of the questions for your registration to be processed.

Registering in Person

If you have a current valid Ohio driver's license, you must provide that number on line 10. If you do not have an Ohio driver's license, you must provide the *last four digits* of your Social Security number on line 10. If you have neither, please write "None."

Registering by Mail

If you register by mail and do **not** provide either a current Ohio driver's license number or the last four digits of your Social Security number, please enclose with your application **a copy** of one of the following forms of identification that shows your name and current address:

Current valid photo identification card, military identification, or current (within one year) utility bill, bank statement, paycheck, government check or government document (except board of elections notifications) showing your name and current address.

Your Signature

Your signature is required for your registration to be processed. In the box next to the arrow by line 14, please affix your signature or mark, taking care that it does not touch surrounding lines or type so it can be effectively used to identify you. If your signature is a mark, include the name and address of the person who witnessed the mark beneath the signature line. If by reason of disability you are unable to physically sign, you may follow specific procedures found in Ohio law (R.C. 3501.382) to appoint an attorney-in-fact who may sign this form on your behalf at your direction and in your presence.

Please see information on back of this form to learn how to obtain an absentee ballot.

FOLD HERE

1. Are you a U.S. citizen? ☐ Yes ☐ No
2. Will you be at least 18 years of age on or before the next general election? ☐ Yes ☐ No
If you answered NO to either of the questions, do not complete this form.

3. Last Name	First Name	Middle Name or Initial	Jr., II, etc.

4. House Number and Street (Enter new address if changed)	Apt. or Lot #	5. City or Post Office	6. ZIP Code

7. Additional Rural or Mailing Address (if necessary)	8. County where you live

9. Birthdate (MO-DAY-YR) (required)	10. Ohio driver's license No. OR last 4 digits of Social Security No. (one form of ID required to be listed or provided)	11. Phone No. (voluntary)

12. PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION - Previous House Number and Street

Previous City or Post Office	County	State

13. **CHANGE OF NAME ONLY** Former Legal Name	Former Signature

I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.

14. **Your Signature →**

Date_____/_____/_____
MO DAY YR

FOR BOARD USE ONLY
SEC4010 (Rev. 07/08)

City, Village, Twp.

Ward

Precinct

School Dist.

Cong. Dist.

Senate Dist.

House Dist.

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: www.sos.state.oh.us or by calling 1-877-767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

R.C. 3503.19

Voters must bring identification to the polls in order to verify identity. Identification may include a current and valid photo identification, a military identification, or a copy of a current utility bill, bank statement, government check, paycheck, or other government document, other than a notice of an election or a voter registration notification sent by a board of elections, that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot. Voters who do not have any of the above forms of identification, including a Social Security number, will still be able to vote by signing an affirmation swearing to the voter's identity under penalty of election falsification and by casting a provisional ballot. For more information on voter identification requirements, please consult the Secretary of State's Web site at: www.sos.state.oh.us or call 1-877-767-6446.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.