

F.	If anyone in your home is pregnant, is she under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name																
	If yes, what is the doctor's name?	If no, she will be referred to someone who can help her find a doctor.																
G.	Has anyone in your home had a pregnancy that ended within the last six months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name																
H.	Is anyone in your home breastfeeding a baby less than 12 months old? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name																
I.	For each person in your home who has earned or unearned income, (such as Social Security, VA pension, workers compensation, child support, lump-sum payments) please complete the lines below.																	
	<table border="1"> <thead> <tr> <th>Name</th> <th>Name of Employer or Income Source</th> <th>Gross Amount</th> <th>How Often Received</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td>\$</td> <td></td> </tr> <tr> <td></td> <td></td> <td>\$</td> <td></td> </tr> <tr> <td></td> <td></td> <td>\$</td> <td></td> </tr> </tbody> </table>	Name	Name of Employer or Income Source	Gross Amount	How Often Received			\$				\$				\$		
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		\$																
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WIC ONLY APPLICANTS ARE NOT REQUIRED TO COMPLETE QUESTIONS J THROUGH O

J.	For each person in your home who has health insurance , please complete the lines below:																								
	<table border="1"> <thead> <tr> <th>Name</th> <th>Insurance Company</th> <th>Policy Number</th> <th>Effective Date</th> <th>Persons Covered</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3.</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Name	Insurance Company	Policy Number	Effective Date	Persons Covered	1.					2.					3.								
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	Note below what type of policy for each line above. (For example, Medical, Dental, Vision) 1. _____ 2. _____ 3. _____ Does anyone in your home have access to group health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			If known, monthly premium payment: 1. _____ 2. _____ 3. _____																					
K.	Has anyone in your home had medical bills in the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, you may be eligible for Medicaid for these bills.	If yes, who?																							
L.	Is there a court order for medical insurance for anyone in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?																							
M.	Have there been any changes in your household income during the last four months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:																								
N.	Do you pay for someone to take care of your children while you work or go to school? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much do you pay per month for child care?																							
O.	CHILD SUPPORT SERVICES. If your application for assistance is denied, you can still ask for child support services. Your signature here is only for the purpose of expressing interest in receiving those services. The county department of human services will make a referral to the child support enforcement agency. That agency will either contact you to complete a child support application, or you may go directly to their office. Ask your caseworker for the address and telephone number for that agency. Your signature also indicates that you understand that you must notify the child support enforcement agency of any change in the information you provide about absent parents, children, new addresses, and telephone numbers. Should you have any questions regarding child support services, please contact the child support enforcement agency.																								
	Signature of Applicant or Authorized Representative			Date of Signature																					

IMPORTANT! You must sign the back of each application form.

Your Rights and Responsibilities for Healthy Start and Expedited Medicaid

Read this page before you sign your name.
A copy of this information will be given to you or mailed to you
by the county department of human services if you request it.

Right to a State Hearing

You have the right to a hearing before the Ohio Department of Human Services if you are not satisfied with actions taken or decisions made by the county department of human services on your Healthy Start application. The form ODHS 4059 Explanation of State Hearing Procedures, which explains how to ask for a hearing and describes the hearing process, will be mailed to you when the county department of human services receives your application.

Reporting Responsibilities for Assistance

You are responsible at all times for giving complete and correct information about yourself and members of your household. You must report to the county department of human services, within 10 days, any change in your circumstances, such as:

- You move to another address
- Someone moves in with you or moves out
- Any household member's income changes
- Someone gets or loses a job
- A child drops out of school or reaches the age of 18
- The amount of medical bills you pay changes
- The end of your pregnancy and/or the birth of your child(ren).

Automatic Assignment of Third Party and Medical Support Payments

You must tell the county department of human services about any medical coverage you have or if someone else is legally responsible for paying medical expenses for you or members of your family. Medicaid does not pay medical expenses that a third party (such as a private health insurer) is supposed to pay.

When you accept assistance from Medicaid, you must agree to transfer to the Ohio Department of Human Services your right to medical payments from a third party for the time you have received Medicaid. If you receive money directly from insurance or any other third party to cover medical expenses that Medicaid has paid on your behalf, or on the behalf of anyone you are legally responsible for, the Ohio Department of Human Services has the right to recover that money from you.

Quality Control Review

Cases are chosen at random throughout the state for review to make sure that people are eligible for the assistance they receive and that payments are in the correct amount. You must cooperate if your case is reviewed.

Release of Information on Social Security Number for Healthy Start, Expedited Medicaid, WIC, Child and Family Health Services, and Children with Medical Handicaps Programs

You must provide the county department of human services with a social security number, or apply for a social security number, for each person in need of assistance. The agency will use the social security number when contacting appropriate persons or agencies to determine your eligibility and verify information you have given; for example, income, past or present employment, financial resources, unemployment compensation, and disability benefits.

The social security number may be provided to health insurers to see if coverage exists to pay all or part of your medical bills. Your social security number will be used in computer matching and program reviews or audits to make sure you are eligible for this program and the school lunch program.

Note: Your social security number is not required for participation in the WIC, Child and Family Health Services, and Children with Medical Handicaps Programs. However, if provided, it will be used for computer matching of program participation and outreach.

If you are not a citizen, you must provide the county department of human services with proof of your alien status, such as an alien registration card or re-entry permit.

I have read my rights and responsibilities, or they have been read to me, and I understand them. I agree to fulfill my responsibilities as described. I agree to provide proof of eligibility if such proof is asked for. I give my consent to make whatever contacts are necessary to determine my eligibility for assistance and to verify information I have given in this application.

I authorize any person who furnishes me with health care or medical supplies to give the Ohio Department of Job and Family Services or the Ohio Department of Health any information related to the extent, duration, and scope of services

provided to me under the Medicaid program, WIC, and other medical assistance programs. In addition to information shown on claim forms, such information may include, but is not limited to, patient medical records, and records showing the date, time, and length of office visits, tests, or treatments and program eligibility.

I also authorize the Ohio Department of Health and the Ohio Department of Job and Family Services to exchange any information I have provided on this form, in order to enable the departments to determine my eligibility for any program administered by them.

I understand that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

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 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 in this application is true and complete to the best of my knowledge.

Signature of applicant who completed this form	Date of signature
Signature of person who helped complete this form	Date of signature

**AGENCY USE ONLY
Pregnancy Verification**

Medical statement attached

Medical chart location (office name)	Patient name and number	
Telephoned (name)	Agency/Business	Call date
Verification statement		

Identification Verification

Woman's name	<input type="checkbox"/> P <input type="checkbox"/> E	Document number
Infant's name	<input type="checkbox"/> P <input type="checkbox"/> E	Document number
Child's name	<input type="checkbox"/> P <input type="checkbox"/> E	Document number
Medical chart location (office name)		

Income Verification

Verification attached (county department of job and family services, employer, other agencies)

Check those that apply			
<input type="checkbox"/> OWF	<input type="checkbox"/> Disability Assistance	<input type="checkbox"/> Disability Assistance—Medical	<input type="checkbox"/> Food Stamps <input type="checkbox"/> Medicaid <input type="checkbox"/> Refugee
Medical card number	Effective date	Food Stamp card number	Effective date
<input type="checkbox"/> Verification statement (document/check stub/letter) used	Income amount	<input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> semimonthly <input type="checkbox"/> monthly	Statement date
Telephoned (name)	Agency/Business	Call date	
Confirmed information			
Other			
Proof of Residence			
<input type="checkbox"/> Ohio License/ID	<input type="checkbox"/> Utility bill	<input type="checkbox"/> Credit bill	<input type="checkbox"/> WIC Reminder Card <input type="checkbox"/> Other:
WIC personnel signature			Date