

OHIO BREAST & CERVICAL CANCER PROJECT (BCCP) MEDICAID APPLICATION

BCCP Medicaid offers free health care coverage to certain women who were screened through the Ohio Department of Health's (ODH) Breast & Cervical Cancer Project (BCCP) and need treatment for breast or cervical cancer or pre-cancerous conditions. If you were screened through ODH's BCCP and want to apply for BCCP Medicaid, follow these steps:

1. **Complete, sign, and date this Medicaid application.** If you do not understand a question, your BCCP case manager can help you. Use additional pages, if needed. Be sure to sign and date the application and attach copies of important documents.
2. **Read, sign and date** the "Your Rights and Responsibilities" form.
3. **Return these completed forms** to your BCCP case manager. If you need treatment for breast or cervical cancer or pre-cancerous conditions, your BCCP case manager will submit this application to the Ohio Department of Transportation (ODT). ODT will contact you about your eligibility for health care benefits.

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?				
<input type="checkbox"/> YES, I want to register to vote.		<input type="checkbox"/> 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.				
First Name of Person Applying		MI	Last Name	
Street Address		City	State Ohio	Zip Code
County of Residence		Home Telephone	Work Telephone	
Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White	U.S. Citizen? * Provide proof of citizenship or alien status. <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary language <input type="checkbox"/> English <input type="checkbox"/> Other (Please specify) _____
Does anyone in your household pay for childcare? If yes, how much per week (total)? \$ _____ For how many children? _____		Does anyone in your household pay child support? If yes, how much per week (total)? \$ _____ For how many children? _____		

Household: Please list everyone, including yourself, who lives in your household. (If anyone in your household is pregnant, additional information may be requested.)

Name (First, MI, Last)	Date of Birth	Relationship to You	Disabled?	Pregnant?
1.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Income: Please provide information below for each person in your household who receives income from any source, including but not limited to annuities, wages, self-employment, Social Security, SSI, VA pension, Workers' Compensation, alimony, child support or medical support.

Name of Person Receiving Income	Employer or Source of Income	Gross Income	Received How Often?
		\$	
		\$	
		\$	
		\$	

Health Coverage. Please indicate any health coverage you currently have. Check all that apply. (Note: This is health coverage for **you**, not other household members.)

No health coverage Medicaid: If you have a spenddown, how much? \$ _____/month

Medicare: Part A Part B Other. Please identify each policy below.

Insurance Company	Policy Number	Please CHECK the services the policy covers		
		<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Ambulance	<input type="checkbox"/> Doctor Visits <input type="checkbox"/> Dental	<input type="checkbox"/> Prescriptions <input type="checkbox"/> Vision
		<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Ambulance	<input type="checkbox"/> Doctor Visits <input type="checkbox"/> Dental	<input type="checkbox"/> Prescriptions <input type="checkbox"/> Vision
		<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Ambulance	<input type="checkbox"/> Doctor Visits <input type="checkbox"/> Dental	<input type="checkbox"/> Prescriptions <input type="checkbox"/> Vision

Retroactive Coverage. Medicaid may be able to pay some or all of your medical expenses for up to three months before you submitted this application. Would you like ODJFS to explore your eligibility for this coverage?

Yes No If yes, please list any answers or information in this application that have changed in the last three months:

BY SIGNING THIS APPLICATION, I AGREE to give documentation and verification of information on this application. I understand this application for Medicaid will be considered only in the event that I am screened for breast and/or cervical cancer under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP), found to have breast or cervical cancer (or pre-cancerous conditions), and need treatment. I understand I may be asked to give consent to the CDJFS to make whatever contacts are necessary to determine my eligibility.

I authorize any person who furnishes health care or medical supplies to give the Ohio Department of Health (ODH) any information related to the extent, duration, and scope of services provided under the Breast and Cervical Cancer (BCCP) Medicaid Program and the BCCP screening program. I also authorize ODT and ODH to exchange any information I have provided on this form, in order 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 needed in order to receive Medicaid.

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 fines 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.**

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

A separate application is required for cash assistance, food assistance, assistance for other family members or other categories of Medicaid. If you are interested in applying for any other form of assistance, please contact your local County Department of Job & Family Services.

Questions? Call your BCCP Case Manager or the Medicaid Consumer Hotline at 1-800-324-8680 or TDD 1-800-292-3572.

To ensure your information is updated, please do the following:

1. Print this form.
2. Complete all required fields.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections. For your county board's address please visit www.OhioSecretaryofState.gov/boards.htm.

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (767-6446).

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.OhioSecretaryofState.gov or by calling 1-877-767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring identification to the polls in order to verify identity. Identification may include current and valid photo identification, a military identification, or a copy of a current (within the last 12 months) 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 pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call 1-877-767-6446.

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