



**OHIO DEPARTMENT OF HEALTH
COMPLEX MEDICAL HELP PROGRAM (CMH)
FAX 614-728-3616**

NOTIFICATION OF CHANGES IN CHILD/FAMILY STATUS

Pgtuqp'eqo r ngvpi "y g'hqto :	P co g'qh'Ci gpe{ :	Dcvg: mm/dd/yyyy
Phone Number:	Fax Number:	

CrkpvP co g:	CMH Ccug #	Dcvg'qh'Dk vj : mm/dd/yyyy
New Address:		
Phone of Client/Parent/Guardian:		Elhgexg'F cvg: mm/dd/yyyy
Dqgu'yj ku'pxqrxg'c'o qxg'q'c'f'htgtgp'eqwpv' "qh'tgukf gpeg? <input type="checkbox"/> Yes <input type="checkbox"/> No New County:	Doetu'yj ku'pxqrxg'c'o qxg'q'c'f'htgtgp'J gcnj 'F gr ctvo gpv? <input type="checkbox"/> Yes <input type="checkbox"/> No New Health Dept:	

NEW/CURRENT INSURANCE INFORMATION FOR THE CLIENT

Nco g'qh'kpuwtcepg'Ego r cp{ :	Pj qp'P wo dgt:
Nco g'qh'kpuwtgf :	Elhgexg'F cvg: mm/dd/yyyy
Pqile{ 'P wo dgt:	Gtqr 'P wo dgt:
Dqgu'f'qw't'ncp'kpenwf g't tguetkr vkp'dgpgkx: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dqgu'f'qw't'wi 'rncp'tgs vktg'o clt'order't j cto ce{ : <input type="checkbox"/> Yes <input type="checkbox"/> No
Nco g'qh'eqo r cp{ "y cv'cf o kplngtu'prescription dgpgkx:	
Dqgu'enkpv'j cxg'f gpcn'kpuwtcepg: Yes <input type="checkbox"/> <input type="checkbox"/> No	Dqgu'enkpv'j cxg'xkukp'kpuwtcepg: <input type="checkbox"/> Yes <input type="checkbox"/> No
P co g'qh'eqo r cp{ "y cv'cf o kplngtu'f gpcn'dgpgkx:	
P co g'qh'eqo r cp{ "y cv'cf o kplngtu'xkukp'dgpgkx:	

What services are not covered by your insurance? (Examples: Orthodontia, Prescriptions, etc.)

CHANGE IN MEDICAID STATUS (check correct line)

<input type="checkbox"/> Arr tqxgf	Ccug #	Dcvg: mm/dd/yyyy
<input type="checkbox"/> Dgplgf	Rgcugp:	Dcvg: mm/dd/yyyy
<input type="checkbox"/> Nq'hqpi gt'grki kdkg	Rgcugp:	Dcvg: mm/dd/yyyy

NAME OF MEDICAID HMO INSURANCE (if applicable):

* If denied or no longer eligible, please include denial copy or notification from ODJFS.

CHANGES IN FAMILY STATUS (parent/guardian name change, change in guardianship, etc):

--

CHILD EXPIRED: <input type="checkbox"/> Please attach Obituary or Death Certificate	Dcvg: mm/dd/yyyy
--	----------------------------

**OHIO DEPARTMENT OF HEALTH
COMPLEX MEDICAL HELP PROGRAM (CMH)
NOTIFICATION OF CHANGES IN CHILD/FAMILY STATUS**

ADDENDUM

Person completing the form (please print):	Name of agency:	Date: mm/dd/yyyy
Phone:	Fax Number:	

[illegible]

The information contained in this facsimile transmission and any other documents which accompany it, is intended only for the personal and confidential use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that you have received this document in error, and that any review, dissemination, distribution, or copying of this communication is strictly prohibited. The facsimile transmission and accompanying documents, may contain information that is privileged, confidential and /or otherwise exempt from disclosure under applicable law. If you have received this communication in error, please call us collect to arrange for the destruction or return of the communication at our expense. Receipt by anyone other than the intended recipient is not a waiver of the client of work product privilege. 8/04