Appendix

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[NAME OF LHD]

[ADDRESS OF LHD]

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
(Name of HC Coordinator)	[Name LHD Representative]
AGENCY: Name CDJFS	DATE:
FAX NUMBER: (CDJFS Fax #)	TOTAL NO. OF PAGES, INCLUDING COVER: 1
PHONE NUMBER: (CDJFS Phone #)	RE: **Lead poisoning case**- verification of Medicaid eligibility and status

PLEASE REPLY TO **[NAME OF LHD REPRESENTATIVE] AT [REPRESENTATIVE TELEPHONE # OR E-MAIL]**

NOTES/COMMENTS:

The Ohio Department of Health (ODH), in an agreement with the Ohio Medicaid, facilitates lead investigations performed for Medicaid-eligible children identified with lead poisoning. This agreement requires ODH and its delegated local boards of health to coordinate the verification of Medicaid eligibility for these individuals with all County Department of Job and Family Services directors and Healthchek coordinators.

On **[Date of lead case referral],** the **[Name of Lead Program]** received a referral for a child with lead poisoning. A current listing of state Healthchek coordinators identifies **[Name of Healthchek coordinator]** as the coordinator assigned to **County Name** County.

Please contact our agency as soon as possible so that we may identify the Medicaid eligibility status of a child with lead poisoning. The name and contact information of the individual responsible for conducting the lead investigation is listed above. We appreciate your prompt attention to this matter. **Also, please let me know if the address below is current, if you have a telephone number or if this child has moved.**

Property Address: [Full address of property here]
Name of child: [Name of Child here]
Child Medicaid Number: [Medicaid Number here]