



Department of Health

**OHIO DEPARTMENT OF HEALTH  
CHILDREN WITH MEDICAL HANDICAPS 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:		Ehgwkg'F cvg: mm/dd/yyyy
Dqgu'yj ku'pxqixg'c'o qxg'q'c'f'htgtgp'eqwpv' "qh'tgukf gpeg? Yes No New County:	Doetu'yj ku'pxqixg'c'o qxg'q'c'f'htgtgp'J gcnj 'F gr ctwo gpv? Yes No New Health Dept:	

**NEW/CURRENT INSURANCE INFORMATION FOR THE CLIENT**

Nco g'qh'kpuwtcepg'Ego r cp{ :	Pj qpg'P wo dgt:
Nco g'qh'kpuwtgf :	Ehgwkg'F cvg: mm/dd/yyyy
Pqite{ 'P wo dgt:	Gtqr 'P wo dgt:
Dqgu'f'qw't'ncp'kpenf g't tguetk' vqp'dgpgkx: Yes No	Dqgu'f'qw't'wi 'r nc'p'tgs vkg'o clt'order't j cto ce{ : Yes No
Nco g'qh'eqo r cp{ "y cv'cf o kplngtu'prescription dgpgkx:	
Dqgu'enkpv'j cxg'f gpcn'kpuwtcepg: Yes No	Dqgu'enkpv'j cxg'xkukp'kpuwtcepg: Yes 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	Rgcup:	Dcvg: mm/dd/yyyy
<input type="checkbox"/> Nq'hpi gt'grki kdkg	Rgcup:	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):**

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<b>CHILD EXPIRED:</b>	Please attach Obituary or Death Certificate	Dcvg: mm/dd/yyyy
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