

**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:

- 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.
- 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 Medicaid (ODM). ODM will contact you about your eligibility for healthcare benefits.

<b>VOTER REGISTRATION APPLICATION ATTACHED – ASSISTANCE AVAILABLE</b>				
If you are not registered to vote where you live now, would you like to apply to register to vote today?				
<input type="checkbox"/> <b>YES</b> , I want to register to vote.		<input type="checkbox"/> <b>NO</b> , I do not want to register to vote.		
<b>If you do not check either box, you will be considered to have decided not to register to vote at this time.</b>				
First Name of Person Applying		MI	Last name	
Street Address			City	State OH
County	Phone number	Date of Birth (mm/dd/yyyy)	Social Security Number (SSN)	
Hispanic/Latino?  <input type="checkbox"/> Yes  <input type="checkbox"/> No	Race (Optional – check all that apply) <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		Are you a U.S citizen?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Primary language  <input type="checkbox"/> English  <input type="checkbox"/> Other ( <i>please specify</i> ) _____		
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 month (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  
 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"/> Doctor Visits <input type="checkbox"/> Prescriptions <input type="checkbox"/> Ambulance <input type="checkbox"/> Dental <input type="checkbox"/> Vision
		<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Doctor Visits <input type="checkbox"/> Prescriptions <input type="checkbox"/> Ambulance <input type="checkbox"/> Dental <input type="checkbox"/> Vision
		<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Doctor Visits <input type="checkbox"/> Prescriptions <input type="checkbox"/> Ambulance <input type="checkbox"/> Dental <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. If you have medical expenses in the past three months, would you like to explore your eligibility for this coverage?    Yes    No

If yes, please list any information or answers 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 Ohio Department of Medicaid (ODM) and the County Department of Job and Family Services (CDJFS) to make whatever contacts are necessary to determine my eligibility.

I authorize any person who furnishes health care or medical supplies to give ODM or 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 ODM 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.

I understand that I must tell ODM if anything changes (and is different than) what I wrote on this application. I can call 1-844-640-6446 to report any changes within 10 days. I understand that a change in my information could affect my eligibility.

I understand that if I receive Medicaid after I turn 55 or while I am considered permanently institutionalized, after my death Medicaid will seek to be repaid from my estate for the cost of services provided to me and/or managed care premiums.

If I am eligible for medical assistance, I am giving ODM my rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving ODM my rights to pursue and get medical support from an ex-spouse or parent.

**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 ( <i>Please Print</i> )	Signature	Date
Authorized Representative or Person Who Completed Form	Signature	Date

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

**Questions? Call your BCCP Case Manager or the Medicaid Consumer Hotline at 1-800-324-8680 or**

**TDD 1-800-292-3572.**

# Voter Registration and Information Update Form

Please read instructions carefully. Please type or print clearly with blue or black ink.  
For further information, you may consult the Secretary of State's website at: [VoteOhio.gov](http://VoteOhio.gov) or call 877-SOS-OHIO (877-767-6446).

## Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

**NOTICE:** This form must be received or postmarked by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Please see information on back of this form to learn how to obtain an absentee ballot.

**Numbers 1 and 2 below are required by law.** You must answer both of the questions for your registration to be processed.

## Identification Requirements

If you have a current Ohio driver's license or state ID card, you must provide that number on line 10. If you do not have an Ohio driver's license or state ID card, you must provide the last four digits of your Social Security number on line 10. If you have neither, please write "None."

## Residency Requirements

Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

## Your Signature

In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

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

I am:  Registering as an Ohio voter  Updating my address  Updating my name

1. Are you a U.S. citizen?  Yes  No  
2. Will you be at least 18 years of age on or before the next general election?  Yes  No  
If you answered NO to either of the questions, do not complete this form.

3. Last Name		First Name		Middle Name or Initial	Jr., II, etc.
4. House Number and Street (Enter new address if changed)			Apt. or Lot #	5. City or Post Office	6. ZIP Code
7. Additional Mailing Address (if necessary)				8. County (where you live)	<b>FOR BOARD USE ONLY</b> SEC4010 (rev. 2/7/23) City, Village, Twp.  Ward  Precinct  School Dist.  Cong. Dist.  Senate Dist.  House Dist.
9. Birthdate (MM/DD/YYYY) (required)	10. Ohio driver's license number, state ID card number, OR last four digits of Social Security number (one form of ID required to be listed or provided)			11. Phone Number (voluntary)	
12. PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION - Previous House Number and Street					
Previous City or Post Office		Previous County	Previous State		
13. CHANGE OF NAME ONLY Former Legal Name			Former Signature		
14. I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.					
<b>Your Signature</b>			<b>Date</b> (MM/DD/YYYY)		
					

**TO ENSURE YOUR INFORMATION IS RECEIVED,  
PLEASE DO THE FOLLOWING:**

1. Print this form.
2. Make sure all required fields are complete.
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 [VoteOhio.gov/Boards](https://VoteOhio.gov/Boards)

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

**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 online at [VoteOhio.gov](https://VoteOhio.gov) or by phone at 877-SOS-OHIO (877-767-6446).

**OHIO VOTER IDENTIFICATION REQUIREMENTS**

Voters must bring photo identification to the polls in order to verify identity. Voters who do not provide identification will still be able to cast a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please visit the Secretary of State's website at [VoteOhio.gov](https://VoteOhio.gov) or call 877-SOS-OHIO (877-767-6446).

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