

APPENDIX H

DATA FIELDS FOR CONSUMER CONTACT RECORD SELECTION FORM

Form Name: Ohio Department of Job and Family Services
CONSUMER CONTACT RECORD

Header: Case Information

Subheadings:

- Case Number
- Category//Sequence (AG)
- Last Name of Primary Information Person (PIP)
- First Name of PIP
- Middle Initial
- Phone Number
- Social Security Number
- Interpreter Services
- Country
- Street Address (Residence)
- City (Residence)
- Zip Code (Residence)
- Street Address (Mailing)
- City (Mailing)
- Zip Code (Mailing)

Header: Selection Information

Subheadings:

- Effective Date
- Old MCP (If change)
- New MCP/FFS
- Reason (If a change)

Header: Assistance Group Member(s) Information Section A

Subheadings:

- Member Name/Last/First
- Relationship
- Sex
- Race
- Ethnicity
- Date of Birth
- Billing Number
- PCP/Hospital
- Current Patient?
- Language

Header: Health Screening Information Section B

Subheadings:

Member Name/Last/First
Medical Condition(s)-List
If Under Age 21 [SSI(Y/N), BMCH(Y/N)]
Comments

Header: Emergency Contact Information

Subheadings:

Emergency Contact Name
Relationship
Area Code/Home Telephone Number
Area Code/Work Telephone Number

Authorization To Treat Minors: If no one can reach me and there is an emergency involving one of my children, or other minor dependents, I give my permission to any doctor, hospital or other medical provider to give necessary emergency care and treatment.

Name
Relationship
Date

I have reviewed the Conditions of Enrollment listed. As the designated caretaker, I agree to the Health Care Selection Conditions and authorize membership of me and/or the other members of my assistance group in the Managed Care Plan selected.

Consumer Signature/Name
Date
Selection Counselor (ODJFS/MCEC Staff Only)
Date (ODJFS/MCEC Staff Only)