

Ohio Department of Job and Family Services  
**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:

1. **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.
2. **Read, sign and date** the "Your Rights and Responsibilities" form.
3. **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 Job & Family Services (ODJFS). ODJFS will contact you about your eligibility for health care 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 here today?				
<input type="checkbox"/> YES, I want to register to vote.		<input type="checkbox"/> NO, 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 <b>Ohio</b>	Zip Code
County of Residence	Home Telephone		Work Telephone	
Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	<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	U.S. Citizen? * Provide proof of citizenship or alien status. <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary language <input type="checkbox"/> English <input type="checkbox"/> Other (Please specify) _____
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 week (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: If you have a spenddown, how much? \$ \_\_\_\_\_/month

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"/> Ambulance	<input type="checkbox"/> Doctor Visits <input type="checkbox"/> Dental	<input type="checkbox"/> Prescriptions <input type="checkbox"/> Vision
		<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Ambulance	<input type="checkbox"/> Doctor Visits <input type="checkbox"/> Dental	<input type="checkbox"/> Prescriptions <input type="checkbox"/> Vision
		<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Ambulance	<input type="checkbox"/> Doctor Visits <input type="checkbox"/> Dental	<input type="checkbox"/> Prescriptions <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. Would you like ODJFS to explore your eligibility for this coverage?

Yes     No    If yes, please list any answers or information 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 CDJFS to make whatever contacts are necessary to determine my eligibility.

I authorize any person who furnishes health care or medical supplies to give the Ohio Department of Job & Family Services (ODJFS) 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 ODJFS 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.

**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, assistance for other family members or other categories of Medicaid. If you are interested in applying for any other form of assistance, please contact your local County Department of Job & 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 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 Web site at: [www.sos.state.oh.us](http://www.sos.state.oh.us) or call 1-877-767-6446.

## 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 the 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 prior to Election Day, please contact your county board of elections.

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

## Registering in Person

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

## Registering by Mail

If you register by mail and do **not** provide either a current Ohio driver's license number or the last four digits of your Social Security number, please enclose with your application **a copy** of one of the following forms of identification that shows your name and current address:

Current valid photo identification card, military identification, or current (within one year) utility bill, bank statement, paycheck, government check or government document (except board of elections notifications) showing your name and current address.

## Your Signature

Your signature is required for your registration to be processed. In the box next to the arrow by line 14, please affix your signature or mark, taking care that it does not touch surrounding lines or type so it can be effectively used to identify you. If your signature is a mark, include the name and address of the person who witnessed the mark beneath the signature line. If by reason of disability you are unable to physically sign, you may follow specific procedures found in Ohio law (R.C. 3501.382) to appoint an attorney-in-fact who may sign this form on your behalf at your direction and in your presence.

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

FOLD HERE

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

3. Last Name	First Name	Middle Name or Initial	Jr., II, etc.
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4. House Number and Street (Enter new address if changed)	Apt. or Lot #	5. City or Post Office	6. ZIP Code
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7. Additional Rural or Mailing Address (if necessary)	8. County where you live	<b>FOR BOARD USE ONLY</b> SEC4010 (Rev. 07/08) City, Village, Twp.  Ward  Precinct  School Dist.  Cong. Dist.  Senate Dist.  House Dist.
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9. Birthdate (MO-DAY-YR) (required)	10. Ohio driver's license No. OR last 4 digits of Social Security No. (one form of ID required to be listed or provided)	11. Phone No. (voluntary)
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12. PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION - Previous House Number and Street		
Previous City or Post Office	County	State

13. CHANGE OF NAME ONLY Former Legal Name	Former Signature
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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.

14. **Your Signature** →

Date      /      /       
           MO      DAY      YR

### **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 at: [www.sos.state.oh.us](http://www.sos.state.oh.us) or by calling 1-877-767-6446.

### **OHIO VOTER IDENTIFICATION REQUIREMENTS**

R.C. 3503.19

Voters must bring identification to the polls in order to verify identity. Identification may include a current and valid photo identification, a military identification, or a copy of a current utility bill, bank statement, government check, paycheck, or other government document, other than a notice of an election or a voter registration notification sent by a board of elections, that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot. Voters who do not have any of the above forms of identification, including a Social Security number, will still be able to vote by signing an affirmation swearing to the voter's identity under penalty of election falsification and by casting a provisional ballot. For more information on voter identification requirements, please consult the Secretary of State's Web site at: [www.sos.state.oh.us](http://www.sos.state.oh.us) or call 1-877-767-6446.

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