Funding Provided By:

Administered By:

Benefits Provided Through:

OHIO BLEEDING DISORDER DENTAL (OBDD) PROGRAM APPLICATION

APPLICATION INSTRUCTIONS

1. Complete, sign, and date the OBDD Program application. Answer all questions completely.
2. Complete, sign, and date the Delta Dental Eligibility Enrollment/Update.
3. Send enrollment fee with completed application. Make check payable to: The Northern Ohio Hemophilia Foundation (NOHF). You will receive a call when you are approved for services to begin.
4. Review the "checklist" (section 7) at the end of this application to ensure you have provided all of the required information for The Northern Ohio Hemophilia Foundation to review and process your application.

SECTION 1: APPLICANT INFORMATION

Use name of bleeding disorder patient and contact information from Head of Household (HOH) in this section.

If more than one bleeding disorder patient lives in the household, use eldest information.

Patient Name: _____ Date of Birth: _____

Dr./HTC: _____ Social Security Number: _____

If patient is a minor, Parent/Guardian/HOH Name: _____

Date of Birth of HOH: _____ SS# of HOH: _____

Marital Status: _____ Gender: ☐Male ☐Female

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Primary Phone Number: _____ Email Address: _____

SECTION 2: ADDITIONAL ENROLLEE INFORMATION

Dependent #1 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

Dependent #2 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

Dependent #3 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

Dependent #4 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

Dependent #5 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

Dependent #6 Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Type: ☐ Spouse ☐ Child Has Bleeding Disorder: ☐ Y ☐ N

SECTION 3: CONFIRM ENROLLMENT GUIDELINES

1. Are you a resident of the state of Ohio? ☐Yes ☐No
2. Are you eligible for dental insurance through your employer? ☐Yes ☐No
3. Are you eligible for dental insurance through your spouse's employer? ☐Yes ☐No
4. If your employer or your spouse's employer offers dental insurance, why are you not covered under that dental plan?

   _____

5. If you are under the age of 26, are you eligible for dental insurance through a parent's employer? ☐Yes ☐No
6. If you are eligible through a parent's employer, why are you not covered under that dental plan?

   _____

7. Do you have coverage under Medicaid, Medicare or (B)CMH – ☐Yes ☐No If yes, circle type.

SECTION 4: EMPLOYMENT INFORMATION, IF CHANGED IN 2016-17

Applicant's employment status: ☐Employed Full-Time ☐Employed Part-Time ☐Self-Employed ☐Unemployed ☐Retired

Spouse's employment status: ☐Employed Full-Time ☐Employed Part-Time ☐Self-Employed ☐Unemployed ☐Retired

Please provide your annual household income: ☐ 0 - $14,999 ☐ $15,000 – $29,999 ☐$30,000 – $64,999 ☐ over $65,000

SECTION 5: ANNUAL ENROLLMENT FEE EXPLANATION

The total cost of each policy through the OBDD program is currently about $1,700 per year, per family. The annual enrollment fee for any **bleeding disorder patient will be $25**, however other members living in the household must pay a **$50 per person**, per year enrollment fee. **There is a maximum enrollment fee for the family of $200**. The OBDD Program will pay the balance of your premiums as long as you stay compliant with the program.

Each person must pay a $100 deductible for dental services other than cleaning and x-rays. This deductible is due directly to your treating dentist. Assistance may be available for the deductible for the BD patient as funds are available.

SECTION 6: VERIFYING YOUR UNDERSTANDING OF THIS APPLICATION

1. I understand that the OBDD Program through NOHF can only accept a limited number of applicants and that priority will be given to bleeding disorder patients and additional family members applicants based on their resources to access dental care.
2. I understand that I am subject to removal and exclusion from this program if this information is false, fraudulent, or contains intentional misrepresentation of facts.
3. I understand that it is my responsibility to inform NOHF of any changes that may affect my eligibility, including any access to dental insurance that I may be offered in the future.
4. I understand that if I move or move my bleeding disorder care out of the state of Ohio, I must notify NOHF so that I can be removed from the program/plan.
5. I understand that annual re-enrollment is necessary in order to remain in this program. I understand that if I do not meet these guidelines: complete the annual re-enrollment process, complete the annual surveys, stay compliant in my treatment plan with the hematologist, visit my dentist at least one time in the program year AND pay my annual enrollment fee by deadline, I will be removed from this program.
6. I understand that if I voluntarily opt out or if I am involuntarily removed from the OBDD Program, I may not reapply for at least one year after my coverage ends.
7. I understand that my identifying information will be shared with Delta Dental and Cascade Hemophilia Consortium for the purposes of verifying my dental benefits and for processing dental premium payments. I understand that my identifying information will NOT be used for marketing of any other services NOHF or Cascade provides.
8. I understand that, by signing below, I certify that all information and documents provided as part of this application are complete, accurate and true to the best of my knowledge and belief.

_____ _____

Applicant's Signature Date

SECTION 7: CHECKLIST FOR SUBMITTING YOUR APPLICATION

☐ **Completed Ohio Dental Plan Application**

- Please be sure the application is fully completed.
- Please provide proof of residency.
- Please provide release of information forms.
- Please be sure your enrollment fee payment made out to NOHF is enclosed.

Do you have questions about this application? Contact Randi Clites at NOHF 216-834-0051 or cell 330-730-1259.

Please mail this application with all required documentation to:

The Northern Ohio Hemophilia Foundation
17407 Lorain Ave Ste 206, Cleveland OH 44111
Fax: 216-834-0055 or scan to randi@nohf.org

DELTA DENTAL®

Eligibility Enrollment/Update

NO FORM IS REQUIRED IF WAIVING DENTAL BENEFITS

Check: ☒ **Indiana** ☐ **Michigan** ☐ **North Carolina** ☒ **Ohio**

Client Name: NOHF Client#/Subclient#: 0893 - 0001

Plan Enrollment/Update Information (*Please indicate type of update and fill in appropriate information*):

Type of Update: ☒ New Enrollment ☐ Termination of Benefits ☐ Change/Correction to Information ☐ Reinstatement

Client/Subclient Transfer
From: Client#/Subclient# **To:** Client#/Subclient#

____ - ____ ____ - ____

Coverage Effective Date: (##/##/####) ____/____/____

Change is for: ☐ Subscriber ☐ Spouse ☐ Dependent

Subscriber Information (*Please fill in for first-time enrollments, changes or corrections*):

Subscriber Name (Last) (First) (M.I.)

Sex: ☐ Male ☐ Female

Status*: ☒ Active ☐ COBRA ☐ Retiree ☐ Surviving

Social Security Number Birthdate (##/##/####) Hire Date (##/##/####)

___ - ___ - ____ __/__/____ __/__/____

Street Address

☐ Check here if this is a new address

City State Zip Code

Spouse/Dependent Information (*Please fill in for first-time enrollments, changes or corrections*):

SPOUSE Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☒ Legal ☐ Surviving

___ - ___ - ____ __/__/____

DEPENDENT #1 Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

___ - ___ - ____ __/__/____

DEPENDENT #2 Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

___ - ___ - ____ __/__/____

DEPENDENT #3 Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

___ - ___ - ____ __/__/____

DEPENDENT #4 Name (Last) (First) (M.I.) Sex: ☐ Male ☐ Female

Social Security Number Birth Date Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

___ - ___ - ____ __/__/____

*See reverse side for instructions.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize payroll deduction from my earning for any contribution I am required to make.

Subscriber's Signature: _____ **Date:** _____

Ohio Dental Plan – Release of Information Form
Authorization to Disclose Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Applicant Name:_____ Date of Birth:_____

Parent/Guardian/Personal Representative (if applicable)

Name:_____ Relationship to Client:_____

AUTHORIZATION

I authorize:

The Northern Ohio Hemophilia Foundation
17407 Lorain Ave Ste 206, Cleveland OH 44111
216-834-0051

TO RELEASE the above-named applicant's protected health information TO AND OBTAIN Information FROM:

_____
Name of Applicant's current Hemophilia Treatment Center and/or Hematologist

_____ _____
Address Phone Number

EXTENT OF AUTHORIZATION

☒ I authorize the release of the above-named applicant's information related to the Ohio Dental Plan application including eligibility for the program, status of the application, dental benefit coverage, dental care needs, and diagnosis and treatment of the above-named applicant's bleeding disorder.

☒ I understand that this release of information form does NOT include records relating to mental health care, communicable diseases (including HIV and AIDS) or alcohol/drug abuse treatment.

This information may be used by the person I authorize to receive this information to assist in determination of eligibility for the Ohio Dental Plan, billing or claims payment and management of dental program benefits and coordination of dental care.

I understand that this consent will remain in effect until I give written notice to discontinue. I have the right to change my mind and revoke this authorization at any time. This must be in writing to The Northern Ohio Hemophilia Foundation. I also understand that any uses or disclosures already made with my permission cannot be taken back. I understand that this consent will automatically expire if I am terminated from the Ohio Dental Program.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for the Ohio Dental Plan unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand that I may request a copy of this signed authorization.

Signature of Applicant or Parent (if minor): _____ Date_____

Signature of Guardian/Personal Representative (if applicable): _____

Ohio Dental Plan - Release of Information Form
Authorization to Disclose Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Applicant Name:_____ Date of Birth:_____

Parent/Guardian/Personal Representative (if applicable)

Name:_____ Relationship to Client:_____

AUTHORIZATION

I authorize:

The Northern Ohio Hemophilia Foundation
17407 Lorain Ave Ste 206, Cleveland OH 44111
216-834-0051

TO RELEASE the above-named applicant's protected health information TO AND OBTAIN Information FROM:

Delta Dental
PO Box 9085
Farmington Hills, MI 48333-9085
800-524-0149

EXTENT OF AUTHORIZATION

☒ I authorize the release of the information contained on the Ohio Dental Plan application form including eligibility for the program, status of the application and dental benefit coverage.

☒ I understand that this release of information form does NOT include records relating to mental health care, communicable diseases (including HIV and AIDS) or alcohol/drug abuse treatment.

This information may be used by Northern Ohio Hemophilia Foundation to verify applicant's dental benefits and to process payments of dental plan premiums. I understand that The Northern Ohio Hemophilia Foundation will NOT use this information in the marketing of any other services NOHF provides.

I understand that this consent will remain in effect until I give written notice to discontinue. I have the right to change my mind and revoke this authorization at any time. This must be in writing to The Northern Ohio Hemophilia Foundation. I also understand that any uses or disclosures already made with my permission cannot be taken back. I understand that this consent will automatically expire if I am terminated from the Ohio Dental Program.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization but that my refusal to sign may affect my eligibility for dental benefits through the Ohio Dental Plan.

By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand that I may request a copy of this signed authorization.

Signature of Applicant or Parent (if minor): _____ Date_____

Signature of Guardian/Personal Representative (if applicable): _____