

**APPLICATION**

**There is no application or enrollment fee**

For additional assistance or to apply by telephone or online, contact us at 1-866-923-7879 (866-9BESTRX), TTY 1-866-763-9630 or go to our website, [www.ohiobestrx.org](http://www.ohiobestrx.org).

**PLEASE PRINT CLEARLY AND USE INK**

- ✚ Complete one application form per individual or family (a family is a couple, a couple with children or an adult with children)

Step 1: How many people are in your family? <input type="text"/>				
Please list all family members who are applying:				
First Name	Last Name	Relationship: <b>Self</b>	Birth Date __ __ __ MM DD YYYY	Sex M F
First Name	Last Name	Relationship: <b>Spouse</b>	Birth Date __ __ __ MM DD YYYY	Sex M F
First Name	Last Name	Relationship: <b>Child</b>	Birth Date __ __ __ MM DD YYYY	Sex M F
First Name	Last Name	Relationship: <b>Child</b>	Birth Date __ __ __ MM DD YYYY	Sex M F
First Name	Last Name	Relationship: <b>Child</b>	Birth Date __ __ __ MM DD YYYY	Sex M F
<b>If you have additional children, please list them on a separate sheet and attach to this form.</b>				

- ✚ Applicant(s) must live in Ohio; if applying as a family, all family members must also live at the same address.

Step 2: What is your home address?		
Street Address	City	
State	Zip Code	Telephone Number: (    )

- ✚ Applicant(s) cannot currently have prescription drug coverage (includes third party insurance from an employer or insurer, Medicaid, disability assistance or children's health insurance).

Step 3: Do you have prescription drug coverage?	
<input type="checkbox"/> No one applying for this program currently has or has had prescription drug coverage in the last 4 months.	
<input type="checkbox"/> Someone applying for this program had prescription drug coverage in the last four months but:	
<input type="checkbox"/> The person(s) who had coverage is/are age 60 or older <input type="checkbox"/> The insurance company that provided drug coverage has filed for bankruptcy <input type="checkbox"/> The person(s) is/are laid off or no longer eligible for coverage through a retirement plan <input type="checkbox"/> The person(s) is/are no longer eligible for Medicaid, disability medical assistance, or children's health insurance	

PLEASE COMPLETE THE BACK OF THIS FORM

**Note: If all applicants are age 60 or older, please skip Step 4.**

✚ If under the age of 60, your yearly or monthly family income cannot be more than income maximums in the chart below. Income maximums are based on the total number of family members not just those that are applying.

1 person	2 people	3 people	4 people
\$32,490/yearly \$2,708/monthly	\$43,710/yearly \$3,643/monthly	\$54,930/yearly \$4,578/monthly	\$66,150/yearly \$5,513 monthly
5 person	6 people	7 people	8 people
\$77,370/yearly \$6,448/monthly	\$88,590/yearly \$7,383/monthly	\$99,810/yearly \$8,318/monthly	\$111,030/yearly \$9,253/monthly

Step 4: What is the income for each adult family member?			
	Yearly Income	or	Last 3 months
Self:	\$ <input type="text"/>		\$ <input type="text"/>
Spouse: (even if spouse is not applying for Ohio Best Rx)	\$ <input type="text"/>		\$ <input type="text"/>
Child over 18 (if applying):	\$ <input type="text"/>		\$ <input type="text"/>
Child over 18 (if applying):	\$ <input type="text"/>		\$ <input type="text"/>

Income must include alimony, interest income on bank accounts and property or additional income

**YOU MUST SIGN THIS APPLICATION TO APPLY FOR OHIO'S BEST RX**

<u>Statement of Truth</u>	
I affirm that the information on this application is true, complete and accurate to the best of my knowledge. I agree to comply with program eligibility in accordance with Ohio Revised Code § 173.76 and to notify Ohio's Best Rx of any change in my address or family size which may affect my eligibility for the program.	
If signing on behalf of the applicant, I also affirm that I am authorized to do so.	
<b>PLEASE NOTE: Knowingly making a false statement on this form is the offense of Falsification, a misdemeanor of the first degree.</b>	
_____	Date _____
Signature or mark of Applicant	
_____	Date _____
Signature of Representative (if applicable)	
Representative's Telephone Number: _____	
Signature of Representative = <input type="checkbox"/> Legal Guardian/Custodian or <input type="checkbox"/> Authorized Representative	
<b>Signature authorizes release of information and enrollment into the Program</b>	

**IF FAXING THIS APPLICATION, YOU MUST FAX BOTH SIDES TO 1-877-923-7879**

Mail application to: **OHIO'S BEST RX PROGRAM**  
PO BOX 408 – TWINSBURG, OH 44087-0408