



There is no application or enrollment fee

For assistance or to apply, call us at 1-866-923-7879 (1-866-9BESTRX), TTY 1-866-763-9630 or go to our website, www.ohiobestrx.org

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

IF FAXING, YOU MUST FAX ALL PAGES TO 1-877-923-7879.

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?

Please list all family members who are applying:

First Name	First Name	First Name	First Name
Last Name	Last Name	Last Name	Last Name
Relationship SELF	Relationship SPOUSE	Relationship CHILD	Relationship
Birth Date ____ ____ ____ MM DD YYYY	Birth Date ____ ____ ____ MM DD YYYY	Birth Date ____ ____ ____ MM DD YYYY	Birth Date ____ ____ ____ MM DD YYYY
Sex - M F	Sex - M F	Sex - M F	Sex - M F

If you have additional children, please list them on a separate sheet and attach to this form.

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?		
Mailing Address		City
State OHIO	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: <ul style="list-style-type: none"><input type="checkbox"/> The person(s) who had coverage is/are age 60 or older.<input type="checkbox"/> The insurance company or employer 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.

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/yr \$2,708/month	\$43,710/yr \$3,643/month	\$54,930/yearly \$4,578/monthly	\$66,150/yearly \$5,513 monthly

5 person	6 people	7 people	8 people
\$77,370/yr \$6,448/month	\$88,590/yr \$7,383/month	\$99,810/yr \$8,318/month	\$111,030/yr \$9,253/month

Step 4: What is the income for each adult family member?			
Yearly Income		or Last 3 months	
Self:	\$	\$	
Spouse:	\$	\$	
Even if spouse is not applying for Ohio Best Rx			
Child over 18: (if applying)	\$	\$	
Additional information may be listed on a separate sheet and attached to this form. Income must include alimony, interest income on bank accounts and property or additional income.			

YOU MUST SIGN THIS APPLICATION TO APPLY.

STATEMENT OF TRUTH

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 Section 173.6 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.

PLEASE NOTE: Knowingly making a false statement on this form is the offense of Falsification, a misdemeanor of the first degree.

_____ Date _____
Signature or Mark of Applicant

_____ Telephone _____ Date _____
Signature of Representative (if applicable)

Representative = Legal Guardian/Custodian or Authorized Representative

Signature authorizes release of information and enrollment into the Program.