Ohio Department of Medicaid

HOME CHOICE APPLICATION

Applicant Name (Last, First, MI)			**Applicant Phone Number**
Is the applicant on Medicaid? ☐ Yes ☐ No	**Medicaid ID Number***(12 digits)*	**Gender** ☐ M ☐ F	**Date of Birth** *(mm/dd/yyyy)*
County	**List any communication barriers**		
Name of Facility		**Date of Admission** *(mm/dd/yyyy)*	
Street Address		**Facility Phone Number**	
City	**State**	**Zip Code**	**Facility FAX Number**

Type of Facility

☐ Nursing Facility
☐ ICF-IID
☐ Hospital
☐ Qualified Residential Treatment Center *(individual under the age of 22 only)*
☐ Psychiatric Hospital *(individual under the of age 22 and over the age of 60 only)*

Referral Source

☐ Self ☐ Friend ☐ Family ☐ Physician
☐ CIL ☐ CLS ☐ LTC Ombudsman ☐ County Board of DD
☐ Nursing Facility ☐ ICF-IID ☐ Hospital ☐ PASRR
☐ Family and Children First Council ☐ Other (*specify*): ☐ Community Agency (*specify*):

Name of person making referral	**Person referring Phone Number**	**Referral Date** (mm/dd/yyyy)

Does the applicant have income?

☐ Yes ☐ No *(specify):*

Does the applicant have a mental health diagnosis?

☐ Yes ☐ No (*specify*):

Does the applicant have a drug and/or alcohol diagnosis?

☐ Yes ☐ No *(specify):*

Does the applicant have a developmental disability diagnosis?

☐ Yes ☐ No *(Specify)*

If yes to any diagnoses, is the applicant receiving treatment or services?

☐ Yes
☐ No

Additional information that will assist in processing this application:

Who else might we contact about the person being referred?	**Contact Phone Number**

The following must be filled out if applicant has a legal guardian or is under the age of 18.

LEGAL GUARDIAN (if applicable)

Name (Last, First, MI)			**Type of Guardianship** ☐ Person ☐ Estate ☐ Person and Estate	
Address	**City**	**State**	**Zip Code**	**Phone Number**

PARENT (if applicant is under the age of 18)

Name (Last, First, MI)				
Address	**City**	**State**	**Zip Code**	**Phone Number**

Signature of Applicant or Legal Guardian (REQUIRED)	**Date** *(mm/dd/yyyy)*

Submit completed form to:

Ohio Department of Medicaid/Office of Operations
HOME Choice Operations Unit
Box 182709, 4th Floor
Columbus, Ohio 43218-2709

Email:
Phone: (888) 221-1560
FAX: (614) 466-6945

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