Reset Form

Ohio Department of Medicaid

HOME CHOICE - APPLICATION

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

Referral Source

☐ Self ☐ CLS ☐ Hospital ☐ ICF/IID ☐ CIL
☐ Friend ☐ Physician ☐ Nursing Facility ☐ LTC Ombudsman ☐ PASRR
☐ Family ☐ Family & Children First Council
☐ Other *(Specify)* ☐ Community Agency *(Specify)*

Name of Person Making Referral	Phone - Person Referring	Referral Date *(mm/dd/yyyy)*

Does Applicant Have Income?
☐ Yes ☐ No

Does Applicant Have a Mental Health Diagnosis? ☐ Yes ☐ No If **Yes,** specify:	If **Yes** (to either), is Applicant receiving treatment?	☐ Yes ☐ No
Does Applicant Have a Drug / Alcohol Diagnosis? ☐ Yes ☐ No		

Additional Information that will assist in processing this application

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

Name of Guardian *(if applicable)*	Type of Guardianship ☐ Person ☐ Estate ☐ Person & Estate
Address	
City, State and Zip Code	Phone - Guardian
Name of Parent *(if applicant is younger than18)*	Phone - Parent
Address	
City, State, and Zip Code	
Who else might we contact about the person being referred?	Phone - Other
Signature of Applicant or Guardian (***REQUIRED***)	Date *(mm/dd/yyyy)*

Submit this form to:

HOME Choice Operations Unit
Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports
Box 182709, 5th Floor
Columbus, Ohio 43218-2709
E-Mail: HOME_Choice@medicaid.ohio.gov Phone: (888) 221-1560 Fax: (614) 466-6945