

Ohio Department of Medicaid  
**OHIO HOME CHOICE DEMONSTRATION PROGRAM  
PROVIDER ENROLLMENT APPLICATION ADDENDUM  
Agency Social Work/Counseling Service (HCA 400)**

**Provider Type: Social Work/Counseling Service (Agency)**

Name	
Phone Number	Medicaid Number

Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Home Choice Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with the Provider agreement.

- My signature below serves as verification that the entity meets the provider qualifications/specifications and the enrollment requirements as a HOME Choice demonstration program as set forth in Ohio Administrative Code (OAC) 5101:3-51-04 and 5101:3-51-05; **(\*Please attach proof of certification from ODMR/DD, ODMH or ODA.)**
- I attest the entity will comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-51-03;
- I attest that all direct care employees meet requirements listed in OAC 5101:3-51-04 (D) (3) (a) (ii);
- I attest that all employees who have in-person contact with consumers have successfully completed criminal records check as set forth in OAC 5101:3-51-03 (A) (1) (b); **(\*Please attach copy of background check policy.)**
- I attest that I have received and read all rules of the Administrative Code governing the HOME Choice demonstration program and the ODM-administered waiver (OAC 5101:3-46-04, 5101:3-47-04 or 5101:3-50-04) on which the participant is enrolled;
- I attest that I am the officer, chief executive officer, or general partner of the organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on the application and this addendum is true and accurate.**

Signature	Date
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