

Ohio Department of Medicaid  
**HOME CHOICE - APPLICATION**

Applicant Name <i>(Last, First, MI)</i>		Phone - Applicant	
Is the applicant on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid ID Number <i>(12 digits)</i>	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth <i>(mm/dd/yyyy)</i>		County
Name of Facility		Date of Admission <i>(mm/dd/yyyy)</i>	
Street Address		Phone - Facility	
City	State	Zip Code	Fax - Facility
Referral Source <input type="checkbox"/> Self <input type="checkbox"/> CLS <input type="checkbox"/> Hospital <input type="checkbox"/> ICF/IID <input type="checkbox"/> CIL <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Nursing Facility <input type="checkbox"/> LTC Ombudsman <input type="checkbox"/> PASRR <input type="checkbox"/> Family <input type="checkbox"/> Family & Children First Council <input type="checkbox"/> Other <i>(Specify)</i> <input type="checkbox"/> Community Agency <i>(Specify)</i>			
Name of Person Making Referral		Phone - Person referring	Referral Date <i>(mm/dd/yyyy)</i>
Does Applicant Have Income? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does Applicant Have a Mental Health Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No      If <b>Yes</b> , specify:		If <b>Yes</b> <i>(to either)</i> , is Applicant receiving treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does Applicant Have a Drug / Alcohol Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Additional Information that will assist in processing this application</b>			
<b>The following must be filled out if applicant has a guardian or is under age 18</b>			
Name of Guardian <i>(if applicable)</i>		Type of Guardianship <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Person & Estate	
Address		Phone - Guardian	
City, State and Zip Code		Phone - Parent	
Name of Parent <i>(if applicant is younger than 18)</i>		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 ( <b>REQUIRED</b> )			Date <i>(mm/dd/yyyy)</i>

**Submit this form to:**  
Ohio Department of Medicaid  
Bureau of Long-Term Care Services and Supports  
HOME Choice Operations Unit  
Box 182709, 5<sup>th</sup> Floor  
Columbus, Ohio 43218-2709

E-Mail: HOME\_Choice@medicaid.ohio.gov   Phone: (888) 221-1560   Fax: (614) 466-6945