

Ohio Department of Medicaid
HOME CHOICE - ELIGIBILITY CHECKLIST

Applicant Name: <i>(Last, First, MI)</i>	Anticipated Discharge Date: <i>(mm/dd/yyyy)</i>
Date of Birth: <i>(mm/dd/yyyy)</i>	Medicaid ID Number: <i>(12 digits)</i>

Facility Name:	Facility Phone Number:
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Facility Address: <i>(Street and Number)</i>		
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City:	Facility County:	Zip Code:
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TYPE OF FACILITY <i>(Check one)</i>			
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> ICF-IID	<input type="checkbox"/> Hospital	<input type="checkbox"/> Qualified Residential Treatment Facility <i>(Children under age 22 only)</i> <i>(To be a qualified institution, facility must be either a separate inpatient facility located in the community with 16 or more beds or part of a larger campus facility with 16 or more total beds.)</i>

LENGTH OF STAY	
NOTE: Participants must have a 90 day (consecutive) length of stay in long term care facilities <i>(Hospital, NF, RTF, ICF-IID)</i> . The 90 days may include consecutive stays in multiple facilities.	
Has the participant met the 90 day (consecutive) length of stay requirement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No , is it anticipated that the 90 day minimum stay will be reached prior to discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has consumer had other stays? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes , list facility name and dates of admission and discharge below.	
Stay 1	Facility Name:	
	Date of Admission: <i>(mm/dd/yyyy)</i>	Date of Discharge: <i>(mm/dd/yyyy)</i>
	Facility Name:	
	Date of Admission: <i>(mm/dd/yyyy)</i>	Date of Discharge: <i>(mm/dd/yyyy)</i>

MEDICAID ELIGIBILITY – Please verify with facility.		
Has the participant had at least one Medicaid claim during their institutional stay? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not at this time		

RECOMMENDED HCBS PROGRAM	
DODD Waiver <input type="checkbox"/> Level 1 waiver <input type="checkbox"/> IO waiver <input type="checkbox"/> SELF waiver	ODM Waiver <input type="checkbox"/> Ohio Home Care waiver <input type="checkbox"/> Transitions Carve-Out waiver
ODA Waiver <input type="checkbox"/> PASSPORT waiver <input type="checkbox"/> Assisted Living waiver	Non-Waiver Medicaid <input type="checkbox"/> Medicaid card/state plan services

Applicant Name: (Last, First, MI)

QUALIFIED RESIDENCE

Has the participant found housing? Yes No

If **Yes**, is the housing a qualified residence? Yes No

If **No**, is it anticipated that the participant will move into a qualified residence at the time of discharge? Yes No

Qualified Resident Type (Information on qualified housing can be found in OAC 5101:3-51-01)

Qualified Residences for HOME Choice must have all the following in order to meet eligibility criteria:

- An individual lease or agreement that satisfies all applicable statutes regarding Tenant and Landlord law;
- Lockable access and egress to the individual's unit;
- Sleeping, bathing, and cooking areas within the unit over which the individual or the individual's family has domain and control; &
- House no more than four unrelated individuals reside within the unit itself. Individuals may live in a complex with multiple units (i.e. a fourplex apartment building), but within an individual unit/home, there may be no more than four unrelated individuals.

Note: Many licensed facilities do not provide residents with individual leases, or provide agreements that do not meet applicable Tenant/Landlord law. When a lease is in doubt, please contact the HOME Choice Operations Unit for review.

EMPLOYMENT

Interested in employment Not interested in employment

Currently employed Other

DIAGNOSES/ COMMENTS: Please provide details that identify strengths, needs, barriers & relevant diagnoses.

Does this person have community living potential? Do you think he/she can be successful and sustainable in the community at this time?

Yes No, explain:

COMPLETED BY:

Name: (Please print) Phone: Date: (mm/dd/yyyy)
Ext:

AGENCY ODA DODD ODM Case Management
PSA Region: County: Agency Name:

Send completed form to:

Ohio Department of Medicaid
Bureau of Long-Term Care Services and Supports
HOME Choice Operations Unit
PO Box 182709, 5th Floor
Columbus, OH 43218-2709

Email: HOME_Choice@medicaid.ohio.gov
Fax Number: 614-466-6945 **Phone:** 888-221-1560