

Ohio Department of Medicaid
OHIO ACCESS SUCCESS PROJECT
APPLICATION

Applicant Name (<i>Last, First, MI</i>)			Phone – Applicant
Is the applicant on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Medicaid Billing Number (<i>12 digits</i>) - -
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (<i>MMDDYY</i>)	Language	County
Name of Facility			Date of Admission (<i>MMDDYY</i>)
Street Address			Phone – Facility
City, State, and Zip Code			Fax – Facility
Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Family <input type="checkbox"/> Hospital <input type="checkbox"/> Friend <input type="checkbox"/> ICF/MR <input type="checkbox"/> Physician		<input type="checkbox"/> Community Agency (specify) <input type="checkbox"/> Other (specify)	Referral Date (<i>MMDDYY</i>)
Referred by (<i>name of person making referral</i>)			Phone - Person referring
Other Information			
Name of Legal Guardian or Authorized Representative (<i>if applicable</i>)			Type of Guardianship <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Person & Estate <input type="checkbox"/> Authorized Rep Phone – Guardian/Authorized Rep
Address			
City, State and Zip Code			
Name of Parent (<i>applicant under 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 , Legal Guardian or Authorized Representative			Date

Send this form to:
Ohio Department of Medicaid
Bureau of Long-Term Care Services and Supports
Ohio Access Success Project
PO Box 182709, 5th Floor
Columbus, OH 43218-2709

Phone: (614) 466-6742
Fax: (614) 466-6945
E-Mail: HOME_Choice@medicaid.ohio.gov