

Ohio Department of Medicaid
HOME CHOICE - TRANSITION COORDINATION SERVICES STATEMENT

Date				
Provider Name		HOME Choice Provider #		
Program Participant Name		Program Participant Medicaid ID #		
Waiver Type (Check One)				
<input type="checkbox"/> Independent Options <input type="checkbox"/> Level One <input type="checkbox"/> State Plan	<input type="checkbox"/> Ohio Home Care <input type="checkbox"/> Transitions MR/DD <input type="checkbox"/> Transitions Carve-Out	<input type="checkbox"/> PASSPORT <input type="checkbox"/> Choices <input type="checkbox"/> Assisted Living		
Deliverables (Indicate by checking the box of the deliverable(s) provided)				
1st Deliverable HOME Choice Referral Amount \$3,000	HCICCU Approved		Date Received	Approved By
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
2nd Deliverable Qualified Housing Secured Amount \$1,000	HCICCU Approved		Date Received	Approved By
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
3rd Deliverable Relocation Completed Amount \$1,000	HCICCU Approved		Date Received	Approved By
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
Comments				
Certification Statement				
<p>By submitting this statement, the provider conveys the following assertions</p> <ul style="list-style-type: none"> • Documentation substantiating the deliverable has been submitted to the HCICCU as required. • Provider has delivered services in accordance with the Transition Coordinator's provider agreement. <p>In addition, the provider agrees to accept each reimbursement of services as noted on this statement (i.e., up to \$5,000 per program participant) as payment in full. No other reimbursement shall be sought from other carriers, program participants, or rendered by Medicaid.</p>				
<p><i>Any questions regarding the payment of this statement should be directed to the HOME Choice FMS at (800) 610-7910.</i></p>				