

**Ohio Department of Medicaid**  
**HOME Choice Residence Verification Document**  
 Security Deposit or First Month Rent Request

**Participant Information**

Please print or type all information on this document.

Name	Medicaid ID Number
Transition Coordinator Agency Name	Effective Date for Move In

At the time of discharge into the community, \_\_\_\_\_, a participant in the Ohio HOME Choice program, will reside with either his/her parent and/or guardian, roommate, friend, or other family member whose name is \_\_\_\_\_. The HOME Choice participant agrees to pay \$\_\_\_\_\_ per month for rent and utilities. If applicable, the Security Deposit is \$\_\_\_\_\_.

If any rent money or security deposit is given to a parent/guardian/family member/roommate/friend of the participant, that individual understands that the funds must be given back to the participants Transition Coordinator Agency.

*The individual has read and understands that rent and/or security deposit funds must be given back to the TC Agency*

**Address Verification**

Please provide all the information below for the individual's living situation. If the participant is moving into a rental property, please list the name and phone number of the Lease/Landlord/Management Company where applicable.

**Participant Housing Information**

Address		
City	State	Zip Code
County	Primary Phone Number	
<b>Lease/Landlord/Management Company Information</b>		
Name	Phone Number	

\_\_\_\_\_

*Property Owner/Relative/Friend Signature*

\_\_\_\_\_

Date

\_\_\_\_\_

*Parent/Guardian Signature (if applicable)*

\_\_\_\_\_

Date

\_\_\_\_\_

*Transition Coordinator Signature*

\_\_\_\_\_

Date

\_\_\_\_\_

*HOME Choice Participant Signature*

\_\_\_\_\_

Date

## Document Instructions

*Based on applicability, please follow the directions below for appropriate submission of this document.*

### When there is no lease

- This form is to be signed by all parties in the presence of the transition coordinator.
- The transition coordinator is responsible for ensuring that the above dwelling meets the HOME Choice Qualified Residence criteria and meets the needs of the HOME Choice participant prior to move-in.
- The transition coordinator is responsible to ensure that the above named person and residence is legally permitted to have the HOME Choice participant reside in these premises.

### **SUBMIT** the document to the **HOME CHOICE OPERATIONS UNIT**

Ohio Department of Medicaid  
HOME Choice Operations Unit  
Bureau of Long Term Care Services and Supports  
Email: [HOME\\_Choice@medicaid.ohio.gov](mailto:HOME_Choice@medicaid.ohio.gov)  
Fax Number: (614) 466-6945

### When submitted to Financial Services Agency

When the Transition Coordinator is seeking reimbursement for Security Deposit/First Month's rent, this form must be completed & submitted with a receipt and the Payment Request Form to the financial services agency identified below.

When the Transition Coordinator is seeking payment directly to the landlord for the Security Deposit/First Month's rent this form, the landlord's W-9 form and the Payment Request Form must be completed and submitted to the financial services agency.

### **SUBMIT BY MAIL, FAX OR EMAIL TO:**

Morning Sun Financial Services  
9400 Golden Valley Rd.  
Golden Valley, MN 55427  
Email: [MS-Ohexpenses@morningsunfs.com](mailto:MS-Ohexpenses@morningsunfs.com)  
Fax Number: (855) 233-5233

- **QUESTIONS** regarding payment should be directed to:

Email: [MS-Ohexpenses@morningsunfs.com](mailto:MS-Ohexpenses@morningsunfs.com)  
Phone Number: (866) 233-7024

*Home Choice; Helping Ohioans Move, Expanding Choice Ohio's Money Follows the Person Demonstration Project CFDS#93.791*