Ohio Department of Medicaid

HOME CHOICE APPLICATION

Applicant Name (*Last)*	*(First)*	*(MI)*	Date of Birth *(mm/dd/yyyy)*

Social Security Number	Phone Number ( )	Email	Gender ☐ M ☐ F

Eligibility Requirements – If you have transitioned through the HOME Choice program after July 2019, you are not eligible to reapply. To qualify for this program, you must be at least 18 years of age, have needs that can safely be met in a home or community-based setting as determined by the Ohio Department of Medicaid or its designee, and meet each of the additional four requirements listed below.

1. Be currently approved for Medicaid at the time of application and throughout HOME Choice program involvement.	Medicaid ID Number *(12 digits)*

2. You must have income or a means of support for such ongoing expenses as rent, utilities, food, etc. *(please check all that apply)*

☐ Social Security Retirement ☐ SSDI ☐ SSI ☐ Veterans Benefits ☐ Workers Compensation ☐ Private Disability Insurance
☐ Pension ☐ Earned Wages (Employment) ☐ Unemployment Benefits ☐ Other (specify): _____

3. You must be legally permitted to leave the long-term facility and relocate to a community setting

☐ Yes ☐ No If No, please describe the situation (e.g. court ordered placement).

4. You must have been in one of the following types of long-term care facilities at the time of application for at least 90 consecutive days: a nursing facility or a hospital.

Name of Current Facility		Date of Facility Admission *(mm/dd/yyyy)*	
Street Address		Facility Phone Number ( )	
City	County	Zip Code	Facility FAX Number ( )

Type of Facility ☐ Nursing Facility ☐ Hospital

Facility Social Worker/Point of Contact *(Name)*	Phone Number ( )	Email *(Preferred)* or Fax Number

If you were in other facilities for care during the past 90 consecutive days, please indicate these below.

Name of Facility	Date of Admission	Discharge Date	Type of Facility

What circumstances led you to be in your current long-term care stay? (check only one)

☐ Physical Disability ☐ Chronic Illness ☐ Surgery ☐ Accident (Motor Vehicle) ☐ Accident (Other)
☐ Mental Illness ☐ Short-term Illness ☐ Substance Use ☐ Accident (Work) ☐ Other *(specify):* _____

What type of housing did you live in just before being in long-term care? (check only one)

☐ My own house ☐ Rented apartment/house ☐ Friend or relative's home ☐ Assisted living
☐ Group home ☐ Incarceration ☐ Homeless ☐ Other (specify): _____

Have you received any of these specific services in the community? (check all that apply)

☐ Home Nursing ☐ Delivered Meals ☐ Personal Care Aide ☐ Case Management ☐ Voucher/Subsidized Housing
☐ Transportation ☐ Housekeeping ☐ Home Modifications ☐ Training/Employment ☐ Utility Assistance

Do you plan on transitioning to the community within the next six months? ☐ Yes ☐ No ☐ Not Sure	Anticipated Date

Do you have housing to live in once you leave the facility? ☐ Yes ☐ No ☐ Not Sure

Do you have friends or relatives who can help you transition to the community? ☐ Yes ☐ No

Do you have friends or relatives who can help you after you transition to the community? ☐ Yes ☐ No

Are you a past Medicaid waiver recipient? ☐ Yes ☐ No If so, which waiver?

Assisted Living ☐ Level One ☐ MyCare Ohio ☐ Ohio Home Care ☐ PASSPORT ☐ SELF ☐

I understand that participation in the Ohio HOME Choice program is voluntary; therefore, if approved, I understand and agree to the following responsibilities as a participant in the HOME Choice program:
(Each box must be checked to be eligible for program and you must agree with each individual statement.)

- ☐ I agree to participate in the HOME Choice program and understand that information obtained by the Transition Coordination Agency may be shared with others as part of my transition planning.
- ☐ I will actively participate in any assessments and meetings necessary to develop a transition plan that ensures my health and safety in a home or community-based setting.
- ☐ I will provide full and accurate information (e.g. credit history, law enforcement involvement, rental history, personal history) to the program's providers so they may plan for and assist me with my transition to a home or community-based setting.
- ☐ If I refuse to participate and cooperate with the Transition Coordination Agency, it may result in my termination from the HOME Choice program.
- ☐ I will forfeit the opportunity to participate in the program if I leave the long-term care facility early against medical advice and/or prior to participating in planning to ensure a safe and orderly discharge to the community.
- ☐ I will lose the opportunity to participate if I fail to meet any of the eligibility requirements.
- ☐ I agree to move into an appropriate residence upon discharge from the long-term care facility.
- ☐ I understand that if I transition to a home or community-based setting with the assistance of this program, I may not reapply for HOME Choice in the future.
- ☐ I understand that the transition coordinator will work with me until I transition and for 30 days after I transition.

Applicant Signature (*or mark*)	**Date** *(mm/dd/yyyy)*	

If the applicant has a guardian, please have the guardian sign and complete this section.	Guardian Signature (*if applicable)*		Date *(mm/dd/yyyy)*
	Guardian Name *(Last)*	*(First)*	*(MI)*

Guardian Street Address	City	State	Zip Code

Guardian Phone ( )	Guardian Email	Guardian Type ☐ Person ☐ Estate ☐ Person & Estate

Person Completing Application *(if other than applicant)*	Phone Number ( )
Relationship to Applicant	Email

Referral Source

☐ Self ☐ Nursing Facility ☐ COA/AAA/PSA ☐ Community Agency (*specify*): _____
☐ Family ☐ Hospital ☐ LTC Ombudsman ☐ Managed Care Provider (*specify*): _____
☐ Friend ☐ Guardian ☐ CareStar/CareSource ☐ Center for Independent Living ☐ Other *(specify):* _____

Submit completed form to:

Ohio Department of Medicaid/Office of Operations
HOME Choice Operations Unit
PO Box 182709, 4th Floor
Columbus, Ohio 43218-2709
Email: HOME_Choice@medicaid.ohio.gov
Phone: (888) 221-1560
FAX: (614) 360-3549