

Ohio Department of Medicaid
OHIO HOME CHOICE DEMONSTRATION PROGRAM
Agency Provider Application Checklist

Below is a checklist for agency providers to reference when submitting a HOME Choice Demonstration Program Provider Enrollment Application/Time Limited Agreement for consideration. Please ensure that you have included:

1. A copy of your Medicare, CHAP, or Joint Commission Certification or Accreditation.
2. A copy of your IRS Form W-9.
3. A copy of your NPI Enumerator notice.
4. Your Provider Enrollment Application/Time Limited Agreement, signed and fully completed.
5. A copy of your Agency's background check policy.

The above items can be submitted in one of the ways below.

Address: Ohio Department of Medicaid HOME Choice Provider Application PO Box 182709, 4 th Floor Columbus, OH 43218-2709	Fax: 614-360-3549	Email: HOME_Choice@medicaid.ohio.gov
---	-----------------------------	--

Contact the HOME Choice Provider Administrator, Brock Robertson at 1-888-221-1560 or by email at HOME_Choice@medicaid.ohio.gov regarding questions about this agreement.