

Ohio Department of Medicaid
HOME CHOICE APPLICATION

Applicant Name (<i>Last</i>)		(<i>First</i>)	(<i>MI</i>)	Date of Birth (<i>mm/dd/yyyy</i>)
Social Security Number	Phone Number	Email		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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 (<i>12-digits</i>)	
2. You must have income or a means of support for such ongoing expenses as rent, utilities, food, etc. (<i>Please check all that apply</i>) <input type="checkbox"/> Social Security Retirement <input type="checkbox"/> Pension <input type="checkbox"/> Earned Wages (<i>Employment</i>) <input type="checkbox"/> Private Disability Insurance <input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Veterans Benefits <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Other (<i>specify</i>) _____				
3. You must be legally permitted to leave the long-term facility and relocate to a community setting. <input type="checkbox"/> Yes <input type="checkbox"/> 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 (<i>Check only one</i>): <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Intermediate Care Facility				
Name of Current Facility			Date of Facility Admission (<i>mm/dd/yyyy</i>)	
Street Address			Facility Phone Number	
City	County	Zip Code	Facility FAX Number	
Facility Social Worker/Point of Contact		Phone Number	Email (<i>preferred</i>) 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? (<i>Check only one</i>) <input type="checkbox"/> Physical Disability <input type="checkbox"/> Chronic Illness <input type="checkbox"/> Surgery <input type="checkbox"/> Accident (Motor Vehicle) <input type="checkbox"/> Accident (Other) <input type="checkbox"/> Mental Illness <input type="checkbox"/> Short-term Illness <input type="checkbox"/> Substance Use <input type="checkbox"/> Accident (Work) <input type="checkbox"/> Other (<i>specify</i>) _____				
What type of housing did you live in just before being in long-term care? (<i>Check only one</i>) <input type="checkbox"/> My own house <input type="checkbox"/> Assisted Living <input type="checkbox"/> Rented apartment/house <input type="checkbox"/> Homeless <input type="checkbox"/> Group Home <input type="checkbox"/> Incarceration <input type="checkbox"/> Friend or relative's home <input type="checkbox"/> Other (<i>specify</i>) _____				
Have you received any of these specific services in the community? (<i>Check all that apply</i>) <input type="checkbox"/> Home Nursing <input type="checkbox"/> Delivered Meals <input type="checkbox"/> Personal Care Aide <input type="checkbox"/> Case Management <input type="checkbox"/> Voucher/Subsidized Housing <input type="checkbox"/> Transportation <input type="checkbox"/> Housekeeping <input type="checkbox"/> Home Modifications <input type="checkbox"/> Training/Employment <input type="checkbox"/> Utility Assistance				
Do you plan on transitioning to the community within the next six months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure			Anticipated Date	
Do you have housing to live in once you leave the facility?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	
Do you have friends or relatives who can help you transition to the community?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	
Do you have friends or relatives who can help you after you transition to the community?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	
Are you a past Medicaid waiver recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, which waiver? <input type="checkbox"/> Assisted Living <input type="checkbox"/> Level One <input type="checkbox"/> MyCare Ohio <input type="checkbox"/> Ohio Home Care <input type="checkbox"/> PASSPORT <input type="checkbox"/> 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 Name <i>(Last)</i>		<i>(First)</i>	<i>(MI)</i>	Guardian Type <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Person & Estate	
Guardian Street Address			City	State	Zip Code
Guardian Phone	Guardian Email				
Guardian Signature <i>(if applicable)</i>				Date <i>(mm/dd/yyyy)</i>	

Person Completing Application <i>(if other than applicant)</i>	Phone Number
Relationship to Applicant	Email

Referral Source

- | | | |
|---|--|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Guardian | <input type="checkbox"/> Community Agency <i>(specify):</i> _____ |
| <input type="checkbox"/> Family | <input type="checkbox"/> COA/AAA/PSA | <input type="checkbox"/> Managed Care Provider <i>(specify):</i> _____ |
| <input type="checkbox"/> Friend | <input type="checkbox"/> LTC Ombudsman | <input type="checkbox"/> Other <i>(specify):</i> _____ |
| <input type="checkbox"/> Nursing Facility | <input type="checkbox"/> CareStar/CareSource | |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Center for Independent Living | |

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