



Request for Approval for Use of Emergency Rental and Utility Assistance

Participant Name: _____

Medicaid ID# _____

Transition Coordinator: _____

Transition Coordinator Agency Name: _____ HC # _____

Emergency rental and utility assistance may be available post-discharge when necessary to prevent reinstitutionalization. **These services are available to cover circumstances, out of the control of the participant, that prevent the participant from paying rent/utilities and are needed to assure health and welfare. These funds must be approved prior to their being accessed.**

Please describe in detail in your email or fax, the reasons behind the need for emergency rental and utility assistance and a plan for ensuring that another emergency request will not be needed for this participant. The amount needed for emergency rental and utility assistance needed should be identified below. A request may not exceed \$650.00 per month nor may it continue for more than nine (9) months of the consumer's 365 day demonstration period. **If requesting more than one month of assistance, enter each month on a separate line and each type of assistance should be on a separate line.** Once the service is approved, it is the responsibility of the Transition Coordinator to submit check requests to the fiscal management service for payment.

Amount Needed	Identify type of assistance (rent or utilities)	Month Needed

Transition Coordinator's Signature

Date

Case Manager's Signature

Date

HC Operations Approval

Date

Transition Coordinator or Case Manager completes signs and submits form to:

HOME Choice Operations Unit
Ohio Department of Medicaid
Email: HOME_Choice@medicaid.ohio.gov
or
Fax Number: 614-466-6945
Phone: 888-221-1560