

Ohio Department of Medicaid  
**HOME CHOICE - APPLICATION**

Applicant Name ( <i>Last, First, MI</i> )			Phone - Applicant		
Is the applicant on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Medicaid ID # ( <i>12 digits</i> )		
Gender <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth ( <i>mm/dd/yyyy</i> )		County	
Name of Facility			Street Address		
Date of Admission ( <i>mm/dd/yyyy</i> )			Phone - Facility		
City		State		Zip Code	Fax - Facility
Referral Source <input type="checkbox"/> Self <input type="checkbox"/> CLS <input type="checkbox"/> Hospital <input type="checkbox"/> ICF/IID <input type="checkbox"/> CIL <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Nursing Facility <input type="checkbox"/> LTC Ombudsman <input type="checkbox"/> PASRR <input type="checkbox"/> Family <input type="checkbox"/> Family & Children First Council <input type="checkbox"/> Other ( <i>Specify</i> ) <input type="checkbox"/> Community Agency ( <i>Specify</i> )					
Name of Person Making Referral			Phone - Person Referring		Referral Date ( <i>mm/dd/yyyy</i> )
Does Applicant Have Income? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does Applicant Have a Mental Health Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No   If <b>Yes</b> , specify:				If <b>Yes</b> (to either), is Applicant receiving treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does Applicant Have a Drug / Alcohol Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Additional Information that will assist in processing this application</b>					
<b>The following must be filled out if applicant has a guardian or is under age 18</b>					
Name of Guardian ( <i>if applicable</i> )			Type of Guardianship <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Person & Estate		
Address					
City, State and Zip Code			Phone - Guardian		
Name of Parent ( <i>if applicant is younger than 18</i> )			Phone - Parent		
Address					
City, State, and Zip Code					
Who else might we contact about the person being referred?				Phone - Other	
Signature of Applicant or Guardian ( <b>REQUIRED</b> )				Date ( <i>mm/dd/yyyy</i> )	

**Submit this form to:**  
HOME Choice Operations Unit  
Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports  
Box 182709, 5<sup>th</sup> Floor  
Columbus, Ohio 43218-2709  
E-Mail: [HOME\\_Choice@medicaid.ohio.gov](mailto:HOME_Choice@medicaid.ohio.gov)   Phone: (888) 221-1560   Fax: (614) 466-6945