Reset Form

Ohio Department of Medicaid

HOME CHOICE - ENROLLMENT REQUEST

The Pre-Transition Case Manager completes this form and submits **within 5 business days** following the participant's discharge from the institution into the community. **All fields are required.**

Participant Name *(Last, First, MI)*	Date of Birth *(mm/dd/yyyy)*
Medicaid ID # *(12 digits)*	Institution Discharge Date *(mm/dd/yyyy)*
Is the participant living with family? ☐ **Yes** ☐ **No**	

Is a guardian *currently* in place? ☐ **Yes** ☐ **No**	**Guardian Name**
	Guardian Address
	City, State and Zip
	Guardian Phone
	Guardian Type ☐ **Person** ☐ **Estate** ☐ **Person & Estate**

Community Residence Information

Street Address	City
Zip Code	County
Phone Numbers Primary #	Alternate #
Completed by *(Please print)*	Date *(mm/dd/yyyy)*
Agency Name	Phone Number

ODM Use Only

CLA will:

- Verify participant's Medicaid eligibility;
- Verify institutional paid Medicaid claim prior to discharge;
- Verify the address above matches the address indicated on the Qualified Residence form and lease; and
- Update database as needed.

Send completed form to:

HOME Choice Operations Unit
Ohio Department of Medicaid/ Bureau of Long Term Care Services & Supports (BLTCSS)
PO Box 182709, 5th Floor
Columbus, OH 43218-2709

Email: HOME_Choice@medicaid.ohio.gov
Fax Number: 614-466-6945
Phone: 888-221-1560

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