Reset Form

Ohio Department of Medicaid

OHIO ACCESS SUCCESS PROJECT APPLICATION

Applicant Name *(Last, First, MI)*			Phone - Applicant
Is the applicant on Medicaid? ☐ Yes ☐ No			Medicaid Billing Number *(12 digits)* - -
Gender ☐ Male ☐ Female	Date of Birth *(MM/DD/YY)*	Language	County
Name of Facility			Date of Admission *(MM/DD/YY)*
Street Address			Phone - Facility
City, State, and Zip Code			Fax - Facility
Referral Source ☐ Self ☐ Nursing Facility ☐ Family ☐ Hospital ☐ Friend ☐ ICF/MR ☐ Physician	☐ Community Agency *(specify)* ☐ Other *(specify)*		Referral Date *(MM/DD/YY)*
Referred by *(name of person making referral)*			Phone - Person referring
Other Information			
Name of Legal Guardian or Authorized Representative *(if applicable)*			Type of Guardianship ☐ Person ☐ Estate ☐ Person & Estate ☐ Authorized Rep
Address			
City, State and Zip Code			Phone - Guardian/Authorized Rep
Name of Parent *(applicant under 18)*			Phone - Parent
Address			
City, State and Zip Code			
Who else might we contact about the person being referred?			Phone - Other
Signature of Applicant , Legal Guardian or Authorized Representative			**Date**

Send this form to:
Ohio Department of Medicaid
Ohio Access Success Project BCSP
PO Box 182709, 5th Floor
Columbus, Ohio 43218

Phone: (614) 466-6742
Fax: (614) 466-6945
E-Mail: BCSP@medicaid.ohio.gov