Reset Form

Ohio Department of Medicaid

Request for Medicaid Home and Community-Based Services (HCBS)

You must receive Medicaid to receive waiver services. If you have not applied for Medicaid or you have applied in the past but have been denied, you must apply at this time.

Section I: To be completed by the individual or HCBS referring agency:

(Please Print)

Name *(Last, First, MI)*	Social Security Number
Address *(Apartment #)*	Date of Birth
City, State, and Zip Code	Phone Number
Name of authorized representative *(Last, First, MI)*	Phone Number
Address of authorized representative *(Apartment #)*	
City, State, and Zip Code of authorized representative	

Indicate applicable waiver(s) below *(check all that apply)*:

- ☐ Ohio Department of Medicaid
  - ☐ Ohio Home Care Waiver
- ☐ Ohio Department of Developmental Disabilities *(specify waiver)*:
  - ☐ Individual Options Waiver
  - ☐ Self Empowered Life Funding (SELF) Waiver
  - ☐ Level One Waiver
- ☐ Ohio Department of Aging *(specify waiver)*:
  - ☐ PASSPORT Waiver
  - ☐ CHOICES Waiver
  - ☐ Assisted Living Waiver
  - ☐ PACE
- ☐ Other *(specify)*:

I authorize the County Department of Job and Family Services (CDJFS) and its designees to explore my eligibility for Medicaid coverage of HCBS waiver services.

Signature of Individual requesting medical assistance (or Authorized Representative)		Date
Name of Person who helped complete this form *(please print)*:	Signature of Person who helped complete this form:	Date

Section II: To be completed by the CDJFS:

Name of CDJFS Case Worker *(please print)*:	Is the individual currently on Medicaid or is an application for Medical Assistance pending? ☐ Yes ☐ No If yes: CRIS-E Number: Application Date:
Signature of CDJFS Case Worker	
Date Received By CDJFS:	