

Ohio Department of Job and Family Services
HOME CHOICE - DEMONSTRATION & SUPPLEMENTAL SERVICES SERVICE PLAN

Participant Name				Medicaid # (12 digits)	
Case Manager			Agency		
Date(s)	Identified Need/Problem	Goal	Intervention/Action	Unit(s) Date Span	Provider Name/Number
					Provider Name
					Provider #
					Provider Name
					Provider #
					Provider Name
					Provider #
					Provider Name
					Provider #
					Provider Name
					Provider #
Needs Assistance With					
HOU Needs safe, affordable housing	GDS Needs relocation goods & services	NG Needs skilled nursing			
INC Needs sustainable income	DME Needs durable medical equipment	ST Needs skilled therapies			
COM Needs to link w/ community resources	SA Needs service animal	IDL Needs assistance with IADLs			
IL Needs assistance w/ independent living	SWK Needs social work counseling	TC Needs transition coordination			
MH Needs mental health counseling	CD Needs specialized communication devices	ADL Needs assistance with ADLs			
NUT Needs nutrition counseling	CM Needs community mentoring				
Approved by ODJFS <input type="checkbox"/> YES <input type="checkbox"/> NO	Approved by (Name)				Date
Comments					