

Ohio Department of Job and Family Services  
**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 Billing Number
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth <i>(mm/dd/ccyy)</i>	Language	County
Name of Facility			Date of Admission <i>(mm/dd/ccyy)</i>
Street Address			Phone - Institution
City, State, and Zip Code			Fax - Institution
Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Physician	<input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospital <input type="checkbox"/> ICF/MR	<input type="checkbox"/> Community Agency <i>(specify)</i>  <input type="checkbox"/> Other <i>(specify)</i>	Referral Date <i>(mm/dd/ccyy)</i>
Referred by <i>(name of person making referral)</i>			Phone - Person referring
Other Information			
Name of Legal Guardian or Authorized Representative <i>(if applicable)</i>			Type of Guardianship <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Person & Estate <input type="checkbox"/> Authorized Rep
Address			
City, State and Zip Code			
Name of Parent <i>(if applicant is under 18)</i>			Phone - Guardian/Authorized Rep
Address			Phone - Parent
City, State, and Zip Code			
Who else might we contact about the person being referred?			
Signature of Applicant, Legal Guardian, or Authorized Representative			Date <i>(mm/dd/ccyy)</i>
<p><b>Send this form to:</b>  <b>HOME Choice Central Intake Unit</b>  <b>ODJFS/BCSP</b>  <b>PO Box 182709, 5<sup>th</sup> Floor</b>  <b>Columbus, Ohio 43218</b>  <b>Phone: (614) 466-6742    Fax: (614) 466-6945    E-Mail: MFP@jfs.ohio.gov</b></p>			
<i>(For Internal Use Only)</i>			
Referral sent to: <input type="checkbox"/> ODA <input type="checkbox"/> ODMR/DD <input type="checkbox"/> ODJFS Case Management			