

**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):**

<input type="checkbox"/> Ohio Department of Medicaid <input type="checkbox"/> Ohio Home Care Waiver
<input type="checkbox"/> Ohio Department of Developmental Disabilities ( <i>specify waiver</i> ): <input type="checkbox"/> Individual Options Waiver <input type="checkbox"/> Self Empowered Life Funding (SELF) Waiver <input type="checkbox"/> Level One Waiver
<input type="checkbox"/> Ohio Department of Aging ( <i>specify waiver</i> ): <input type="checkbox"/> PASSPORT Waiver <input type="checkbox"/> CHOICES Waiver <input type="checkbox"/> Assisted Living Waiver <input type="checkbox"/> PACE
<input type="checkbox"/> Other ( <i>specify</i> ):

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 <i>(please print)</i> :	Signature of Person who helped complete this form:	Date

**Section II: To be completed by the CDJFS:**

Name of CDJFS Case Worker ( <i>please print</i> ):	Is the individual currently on Medicaid or is an application for Medical Assistance pending? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes: CRIS-E Number: Application Date:
Signature of CDJFS Case Worker	
Date Received By CDJFS:	