

Ohio Department of Medicaid
HOME Choice Payment Request
Community Transition Services (Goods and Services)

Instructions: The Transition Coordinator should submit this document directly to Morning Sun Financial Services (address below). Copies of receipts should be submitted with this payment request document within 2 weeks of the receipt date. Please note: when reimbursement is being requested for an entity other than the TC Agency, a separate payment request form and W9 must be submitted for that entity.

Request Date				
Participant Last Name		First Name	MI	Medicaid Billing Number
Transition Coordinator Agency Name			Home Choice Provider Number	
Contact Person		Phone Number		Email Address
Mailing Address		City	State	Zip Code

Item Number	Quantity	Receipt Date	Item Description	Unit Price	Total Amount
Total					

Name to which Checks should be made Payable		<input type="checkbox"/> Overnight Check Required <i>(Overnight Cost Paid by Participant from Transition Services Funds)</i>		
Mailing Address		City	State	Zip Code

By submitting this request, the provider affirms that the items for which reimbursement is being requested were purchased for, and delivered to, the identified HOME Choice participant in accordance with the policies and procedures governing the HOME Choice program.

Signature	Agency	Date
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Submit by Mail or Fax to;
Morning Sun Financial Services
9400 Golden Valley Rd.
Golden Valley, MN. 55427
Fax: (855) 233-5233

**Questions Regarding Payment
should be directed to:**
Email MS-Ohexpenses@morningsunfs.com
Phone: (866) 233-7024