

Ohio Department of Medicaid  
**HOME CHOICE - CHANGE IN STATUS**

Participant Name <i>(Last, First, MI)</i>		Medicaid ID # <i>(12 digits)</i>		
<b>Section 1: PRE-ENROLLMENT TERMINATION</b> <i>Complete Section 1 <u>only</u> if participant terminates or withdraws <u>before enrollment</u> into the program.</i>				
Effective Date <i>(mm/dd/yyyy)</i>				
Reason <i>(Check one below.)</i>				
<input type="checkbox"/> Too physically ill	<input type="checkbox"/> Individual would not cooperate in care plan development			
<input type="checkbox"/> Too cognitively impaired	<input type="checkbox"/> Service needs greater than what could be provided in the community			
<input type="checkbox"/> Mental health needs exceed capacity of program to meet them	<input type="checkbox"/> Death			
<input type="checkbox"/> Guardian refused participation	<input type="checkbox"/> Individual did not choose MFP qualified residence			
<input type="checkbox"/> Could not locate appropriate housing arrangements	<input type="checkbox"/> Could not secure affordable housing			
<input type="checkbox"/> Individual changed his/her mind	<input type="checkbox"/> Other <i>(You must specify.)</i>			
<b>Section 2: INSTITUTIONALIZATION OR TRANSFER FROM ONE FACILITY TO ANOTHER AFTER ENROLLMENT</b> <i>Complete Section 2 <u>only</u> if participant is admitted to a facility <u>after enrollment</u> into the program.</i>				
Admission from				
<input type="checkbox"/> Residence		<input type="checkbox"/> Another Institution		
Admission Date <i>(mm/dd/yyyy)</i>				
Facility Name				
Facility Address		City	State	Zip
Facility Type				
<input type="checkbox"/> Nursing Facility		<input type="checkbox"/> ICF/IID	<input type="checkbox"/> Hospital	<input type="checkbox"/> Residential Treatment Facility
<input type="checkbox"/> Other <i>(Specify.)</i>				
Reason for Institutionalization <i>(Check one.)</i>				
<input type="checkbox"/> Acute care hospitalization followed by long term rehabilitation		<input type="checkbox"/> Loss of housing		
<input type="checkbox"/> Deterioration in cognitive functioning		<input type="checkbox"/> Loss of personal caregiver		
<input type="checkbox"/> Deterioration in health		<input type="checkbox"/> By request of participant/guardian		
<input type="checkbox"/> Deterioration in mental health		<input type="checkbox"/> Lack of sufficient community services		
<b>Section 3a: RESIDENCE INFORMATION</b> <i>Complete Sections 3a and 3b if participant is discharged from a facility back into the community OR moves from one qualified residence to another after enrollment into the program. All fields are required information.</i>				
Move Type			Effective Date <i>(mm/dd/yyyy)</i>	
<input type="checkbox"/> Discharge from Facility		<input type="checkbox"/> Change in Residence		
Current Phone # <i>(xxx-xxx-xxxx)</i>	Residence Address			
City	County	State	Zip	
Is participant living with family? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Participant Name (Last, First, MI)	Medicaid ID # (12 digits)
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**Section 3b: RESIDENCE TYPE**  
 Complete **both** parts of section 3b when participant moves from one qualified residence to another or is discharged from a facility.

IS THE RESIDENCE

A residence in a community-based residential setting in which no more than 4 unrelated individuals reside? If so, indicate residence type. (Check one.)

<input type="checkbox"/> Adult foster homes	<input type="checkbox"/> Adult family homes
<input type="checkbox"/> Non-ICF/IID residential facilities	<input type="checkbox"/> Family foster home for children
<input type="checkbox"/> Type 1 residential facilities	<input type="checkbox"/> Type 2 residential facilities
<input type="checkbox"/> Treatment foster home for children	<input type="checkbox"/> Group homes for children
<input type="checkbox"/> Medically fragile foster home	<input type="checkbox"/> Pre-adoptive infant foster home for children

OR, is the residence

A home owned/rented by the participant

A home owned/rented by a family member or friend

An apartment/house leased by the participant (not assisted living)

An apartment leased by the participant (assisted living)

HOUSING SUPPLEMENT(S) OBTAINED FOR HOME OR RESIDENCE (Check all that apply.)

<input type="checkbox"/> Low income housing tax credit unit	<input type="checkbox"/> Unit subsidized with HOME funds
<input type="checkbox"/> Section 202 unit	<input type="checkbox"/> Unit subsidized with Housing Trust Funds
<input type="checkbox"/> Unit subsidized with CDBG funds	<input type="checkbox"/> VA subsidy
<input type="checkbox"/> USDA Rural Development unit	<input type="checkbox"/> Funds for assistive technology for housing
<input type="checkbox"/> Funds for home modification	<input type="checkbox"/> Section 811 unit
<input type="checkbox"/> Housing Choice Vouchers	<input type="checkbox"/> Other (Describe.)
	<input type="checkbox"/> Not Applicable

**Section 4: DISENROLLMENT FROM HOME CHOICE**  
 Complete only if participant terminates the program after enrollment.

Effective Date (mm/dd/yyyy)

**Reason (check one)**

<input type="checkbox"/> Moved to an institutional setting ( <b>Complete Section 2.</b> )	<input type="checkbox"/> Completed 365 days of participation in program
<input type="checkbox"/> Death of participant	<input type="checkbox"/> Suspended eligibility
<input type="checkbox"/> Moved ( <b>Complete section 3a.</b> )	<input type="checkbox"/> No longer needed services
<input type="checkbox"/> Other (You <b>must</b> specify.)	<input type="checkbox"/> Loss of Medicaid

**Section 5: COMPLETED BY**

Name	Agency	Phone	Ext
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**Send completed form to:**  
 HOME Choice Operations Unit  
 Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports  
 PO Box 182709, 5<sup>th</sup> Floor  
 Columbus, OH 43218-2709

Email: HOME\_Choice@medicaid.ohio.gov  
 Fax Number: 614-466-6945