

Ohio Department of Medicaid
**OHIO ACCESS SUCCESS PROJECT
 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 (<i>12 digits</i>) - -
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (<i>MM/DD/YY</i>)	Language	County
Name of Facility			Date of Admission (<i>MM/DD/YY</i>)
Street Address			Phone - Facility
City, State, and Zip Code			Fax - Facility
Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Family <input type="checkbox"/> Hospital <input type="checkbox"/> Friend <input type="checkbox"/> ICF/MR <input type="checkbox"/> Physician	<input type="checkbox"/> Community Agency (<i>specify</i>) <input type="checkbox"/> Other (<i>specify</i>)		Referral Date (<i>MM/DD/YY</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>applicant 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			Phone - Other
			Date

Send this form to:
 Ohio Access Success Project
 Ohio Department of Medicaid/BCSP
 PO Box 182709
 Columbus, Ohio 43218-2709

Phone: (614) 466-6742
 Fax: (614) 466-6945
 E-Mail: BCSP@medicaid.ohio.gov