

**Initial Enrollment Checklist for \_\_\_\_\_**

- \_\_\_ Person's name spelled correctly. No nicknames used.
- \_\_\_ Date of birth verified.
- \_\_\_ Correct county where person will be receiving services.
- \_\_\_ Social security number verified. Number does not include a "C".
- \_\_\_ Address is where the person will reside after enrollment. City and zip code included.
- \_\_\_ Guardian's name and address has been verified to be current. City and zip code included.
- \_\_\_ If a replacement, information regarding formerly enrolled individual completed.
- \_\_\_ Protective level of care marked yes or no.
- \_\_\_ Condition(s) that led to the person's developmental disability is indicated.
- \_\_\_ Prescreen completed for Level 1 waiver (PLEASE KEEP IN FILE AT THE COUNTY BOARD)
- \_\_\_ Current functional limitations are indicated.
- \_\_\_ That the person could benefit from skills acquisition is indicated.
- \_\_\_ Level of care is recommended.
- \_\_\_ Proposed date of services is indicated.
- \_\_\_ Document is signed, titled, and dated.
- \_\_\_ Psychological evaluation is signed by an Ohio licensed psychologist or psychiatrist.
- \_\_\_ Medical evaluation is signed by an Ohio licensed physician and includes date(s) of onset of condition(s) leading to developmental disability.
- \_\_\_ Freedom of Choice form indicates that person wants HCBS waiver services. Form is signed and witnessed. If there is a guardian, guardian has signed. Service support administrator has signed. All signatures are dated. Freedom of Choice form is the new form.
- \_\_\_ 2399 has been submitted to CDJFS.
- \_\_\_ Medicaid eligibility has been established.
- \_\_\_ Correct address has been given to CDJFS.

Form completed by: \_\_\_\_\_

Name

Title

Date