



Ohio Department of Mental Retardation and Developmental Disabilities

HCBS WAIVER TRANSMITTAL

NAME OF INDIVIDUAL APPLICANT			
NAME OF APPLICANT IF AGENCY			
STREET ADDRESS, CITY AND ZIP CODE. (DO NOT USE PO BOX)			OHIO
COUNTY			
EMAIL ADDRESS (IF AVAILABLE)			
SOCIAL SECURITY NUMBER OR TAX ID / EIN			DATE:
TELEPHONE NUMBER	(AREA CODE FIRST)		
I have submitted a <u>NOTARIZED</u> application (<i>and all required supporting documentation</i>) for certification to deliver the following Individual Options (I/O) and Level One (L-1) Waiver service(s).		I am prepared to deliver services in the following counties:	
<input type="checkbox"/>	Adult Foster Care IO		
<input type="checkbox"/>	Adaptive & Assistive Equipment IO		
<input type="checkbox"/>	Adult Day Support or Vocational Habilitation IO & L1 Agency		
<input type="checkbox"/>	Environmental Accessibility Adaptations L1		
<input type="checkbox"/>	Environmental Modifications IO		
<input type="checkbox"/>	Home Delivered Meals IO		
<input type="checkbox"/>	Homemaker/Personal Care IO & L1		
<input type="checkbox"/>	Interpreter IO		
<input type="checkbox"/>	Nutrition IO		
<input type="checkbox"/>	Respite IO & L1 Agency Only		
<input type="checkbox"/>	Informal Respite L1 Individual Only		
<input type="checkbox"/>	Personal Emergency Response Systems L1		
<input type="checkbox"/>	Social Work IO		
<input type="checkbox"/>	Specialized Medical Adapt/Assist Equipment & Supplies L1		
<input type="checkbox"/>	Supported Employment Enclave and Community IO & L1		
<input type="checkbox"/>	Transportation L1		
<input type="checkbox"/>	Transportation Mileage Other than to Access Adult Day Services IO		
<input type="checkbox"/>	Non Medical Transportation Per Trip or Per Mile Rate IO & L1		

FOR STATE USE ONLY

ODMR REPRESENTATIVE SIGNATURE	MBS CONTRACT #	EFFECTIVE DATE	DATE TO ODJFS
ODJFS REPRESENTATIVE SIGNATURE	MEDICAID PROVIDER NUMBER	DATE	