

DODD Initial Application Checklist for _____

- Person's name spelled correctly. No nicknames used.
- Date of birth verified.
- Correct county where person will be receiving waiver services.
- Social security number verified.
- 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) is indicated.
- Prescreen completed for Level 1 and SELF waiver **(Please keep in file at 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 completed by an Ohio licensed psychologist or psychiatrist.
- Medical evaluation is completed 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 here is a guardian, guardian has signed. Service support administrator has signed. All signatures are dated.
- 2399 has been submitted to CDJFS.
- Medicaid eligibility has been established.
- Correct address has been given to CDJFS.

Form completed by: _____