



New Client Move-in Checklist

Client Name: _____

Address: _____

Move in date: _____

Consumer #/Client ID: _____

Docs Needed:

- State ID
- Social Security Card
- Birth Certificate
- Food Stamp Card
- Medicaid Card
- Medicare Card
- Guardian paperwork
- Trust information
- Pre-need Docs
- Previous payee and/or Provider
- Parents name, DOB, and social if possible
- VA Benefit information
- Award Letters for SS and/or VA benefits
- Employment information
- ISP (15 days Prior to move in)
- Start-up funds?
- Current Signed Lease
- Authorized Rep Medicaid Forms

Ohio Department of Medicaid
Designation of Authorized Representative

Section 1 (Please Print)

Name of Applicant/Recipient		Medicaid Billing Number or SSN		County	
Street Address (include Apt #)		City		State	Zip
I hereby authorize the following person or entity to act as my representative.					
This authority lasts until _____ (specify a date or event), or until it is revoked by me in writing.					
Name of Representative		Title		Company	
Home Phone	Work Phone		Email Address		
Mailing Address		City		State	Zip
<p>I authorize my representative to do the following on my behalf:</p> <p><input type="checkbox"/> Act on my behalf in all matters with the agency ["agency" includes the County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM), and ODM's contracted designees].</p> <p>OR only the specific actions selected below:</p> <p><input type="checkbox"/> Assist with my application/renewal for benefits <input type="checkbox"/> Represent me at a state hearing</p> <p><input type="checkbox"/> Provide verifications to the CDJFS on my behalf <input type="checkbox"/> Receive and respond to copies of all correspondence</p> <p><input type="checkbox"/> Discuss and receive information regarding my financial and medical information including protected health information (PHI)*</p> <p><input type="checkbox"/> Other (please specify)</p>					
*NOTE You must complete Section 2 of this form if this authorization is intended to allow the use or disclosure of PHI.					
While this authorization is in effect, all notices sent by the CDJFS and/or ODM will also be sent to your authorized representative.					
<p>Signatures. This form has no effect unless signed by both the person granting authority <u>and</u> by the authorized representative. By signing below, the authorized representative agrees to maintain the confidentiality of any information regarding the applicant/recipient provided by the agency. If the authorized representative is a provider, staff member or volunteer of an organization, then the authorized representative also agrees to adhere to the regulations cited in 42 C.F.R. 435.923(e).</p>					
Signature of Person Granting Authority (Applicant/Recipient or Parent/Guardian)				Date	
Signature of Authorized Representative		Title (if employee of an organization)		Date	

Section 2

Authorization for the Use and Disclosure of Protected Health Information

Name of Applicant/Recipient		Case Number/Medicaid ID	Date of Birth
Address	City	State	Zip Code

The County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM) and ODM's contracted designees (including Medicaid managed care plans) are authorized to disclose my protected health information (PHI) to my authorized representative designated in Section 1 of this form.

I hereby authorize the use or disclosure of my protected health information (PHI) as described below. I understand PHI can include the following types of information, and authorize its disclosure: medical records; substance abuse care; vision care; reproductive care; mental health; communicable disease; pharmacy; HIV/AIDS; dental records; and psychiatric care.

This protected health information may be disclosed:

The information is being released for the following purpose(s)

Terms and Conditions

By signing below, I hereby authorize the disclosure of my PHI by the agency. I understand that:

- This authorization expires on the following date or event _____, or upon revocation by me in writing, whichever occurs first.
- I may revoke this authorization at any time. If I revoke this authorization, the revocation is not effective for the use or for the disclosure of my information that has already occurred.
- Any information used or disclosed pursuant to this authorization could be re-disclosed by the person or entity receiving the information, and will likely no longer be protected by federal privacy regulations.
- This authorization is voluntary and that I may refuse to sign it. The provision of treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- In the event my records contain psychotherapy notes, a separate authorization may be required for the release of any psychotherapy notes.
- This authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

By signing below, I confirm that I have read and understand the contents of this authorization, and confirm that the contents are consistent with my direction to the entity releasing my information.

Signature of Applicant/Recipient	Date
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If this form is signed by someone other than the Applicant/Recipient, please describe the authority to act on the individual's behalf (such as Power of Attorney or Legal Guardian). If not already on record with the agency, please provide legal documentation showing this authority.

Transfer of Representative Payee Responsibilities/Authorized Representative

Date: _____

Client Name: _____

Social Security Number: _____

This letter will serve to notify that I, _____ will be transferring Representative Payeeship and Authorized Representative for

_____ to Choices In Community Living Inc. I have been made aware of how Choices In Community Living Inc. handles client funds and Representative Payee matters. Choices In Community Living will be responsible for notifying the Social Security Administration, Job and Family Services and all government/non-government entities of any housing, income, or status changes once the Representative Payee transfer has been established. I also understand that upon my request I can inquire about the funds of the clients and how his/her money is being dispersed. I understand that until Choices In Community Living is made payee, I will forward all government funds (Social Security, VA, Pension etc.) for

_____ to Choices In Community Living Inc. Client banking no later than the fifth of every month. I understand this will be used to pay all of his/her living expenses. I further understand that it can take up 120 days for Choices In Community Living to become payee.

Previous Payee Print Name _____

Previous Payee Signature _____

Payee Address _____

Payee Phone Number _____