

**Ohio Department of Job and Family Services  
Ohio Home Care Program**

## Consumer Service Request for a Provider

<b>Consumer Name</b>
<b>Medicaid ID Number (Ohio Medicaid 12 digit Billing Number)</b>
<b>Case Manager</b>

I am requesting \_\_\_\_\_ to become my Medicaid provider.  
*(Print Provider's Name)*

The provider meets eligibility requirements for a provider serving a consumer as specified in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04.

I have informed my case manager, who has acknowledged my request and has given their approval. I understand that I am responsible for training my providers and for reporting incidents as outlined in the ODJFS-administered waiver rules.

\_\_\_\_\_  
*(Signature of Consumer or Authorized Representative)*

\_\_\_\_\_  
*(Date)*

### To be Completed by the Applicant

I can attest to the fact that above name consumer has selected me to provide services as a non-agency personal care aide through the consumer directed option. I also understand that I jeopardize my enrollment as a Medicaid Provider if any of the information here or in my application is not true.

\_\_\_\_\_  
*(Signature of Provider Applicant)*

\_\_\_\_\_  
*(Date)*