Ohio Client Intake Packet

Ohio Medicaid Long-Term Care (Nursing Facility + HCBS Waivers)

1) Applicant Information

Full Name: _____

DOB: _____ SSN: _____

Address: _____

City/State/ZIP: _____ County: _____

Phone: _____

Email: _____

Medicare #: _____ Medicaid ID #: _____

2) Household & Legal Authority

Spouse Full Name (if married): _____

Spouse DOB: _____ Spouse SSN: _____

Primary Contact (if not applicant): _____

Relationship: _____ Contact Phone: _____

3) Care Setting & Goal

Current Setting (home/AL/rehab/NF): _____

Facility Name (if applicable): _____

Admission Date: _____ Expected Admission: _____

4) Functional Snapshot (Level-of-Care)

Primary Diagnoses: _____

Needs help with ADLs (check all):

- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Transfers
- ☐ Eating
- ☐ Walking

5) Income Snapshot (Monthly Gross)

Applicant income sources (SS/pension/VA/etc): _____

Spouse income sources (if married): _____

6) Assets Snapshot (List all that apply)

- ☐ Checking/Savings/Money Market
- ☐ CDs
- ☐ Brokerage (stocks/bonds/funds)
- ☐ Retirement (IRA/401k/403b/457)
- ☐ Annuities (all contracts)
- ☐ Life insurance cash value
- ☐ Home
- ☐ Other real estate/land/timeshare
- ☐ Vehicles (car/truck/RV/boat)
- ☐ Trusts (revocable/irrevocable/SNT)
- ☐ Business interest/LLC/partnership
- ☐ Burial/funeral plans/plots

7) 60-Month Look-Back (Transfers/Red Flags)

- ☐ Gifts to others
- ☐ Large cash withdrawals
- ☐ Property transfers
- ☐ Accounts closed
- ☐ Loans/promissory notes
- ☐ Caregiver payments

Notes (dates/amounts/to whom): _____

Marital Status

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated

Legal Authority

- ☐ Power of Attorney (POA)
- ☐ Guardianship/Conservator
- ☐ Authorized Representative

Applying For

- ☐ Nursing Facility Medicaid
- ☐ HCBS Waiver (e.g., PASSPORT)
- ☐ Not sure (screening)