

County Board Replacement Waiver Capacity Request Form

In order to request replacement waiver capacity, please complete this form in its entirety.

ODMRDD will act only upon requests authorized by a County Board Superintendent or a COG Director acting on behalf of a County Board of MRDD.

Date of Request (DD/MM/YYYY): ___/___/_____

Replacement Waiver Type: (check one)

<input type="checkbox"/> Individual Options (IO)	<input type="checkbox"/> Level One (LI)
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Applicant Information (NEW person who will be assigned replacement waiver capacity)

Last Name:	First Name:
Social Security Number (if known)	Medicaid Billing Number (if known)

Replacement Information (FORMER waiver recipient being replaced)

Last Name:	First Name:
Social Security Number (if known)	Medicaid Billing Number
Last date of waiver services:	

When requesting replacement capacity, the county must update the PICT queue to place this person at the top of the PICT queue. Once the person is placed at the top of the PICT queue, ODMRDD will enter the 'DMR Approval of Submission' field and then notify the county the waiver capacity has been assigned to the person.

Any individual PICT record with the 'DMR date of approval' already indicated should be assumed to have waiver capacity available to them.

Both of the following boxes must be checked:

I understand that by submission of this Replacement Waiver Request Form the County Board has replaced capacity associated with a disenrollment within the county within this waiver year.

I understand that responsibility for the local match to serve this individual is the obligation of the requesting County Board of MR/DD upon enrollment of the individual.

County Name (required)	Superintendent/COG Director Name (required)
Email address of Superintendent/COG Director making request (required)	

SUBMIT THIS REQUEST FORM TO: waivercapacity-support@odmrdd.state.oh.us

Or Fax at: (614) 644-0501