AREA AGENCY ON AGING
Ohio District 5 | Serving North Central Ohio

LOC Assessment Referral Form

The contents of this document may be confidential and are intended only for the person(s) to whom this fax is addressed

DATE:	**SEND TO: pre-ad@aaa5ohio.org**
SENT BY:	
PHONE:	

Before requesting a LOC assessment, please complete the following:

- **Please Verify Type of Medicaid: Active Traditional:_____Pending:_____**
  (Please note that QMB is an assistance program and not Traditional Medicaid)
- **Complete the PAS in HENS and provide a copy of the PAS Review Results Letter**
  *****IF a Level II Referral is being made, the PAS process is not complete until there are Determinations made from OHMHAS or ODODD or in some cases both. Please also include a copy of the PAS and Determination Letters for all Level II Referrals before requesting a LOC Assessment*****

Consumer Name: _____

Date of Birth: _____SS#_____

Address:_____

City:_____ZIP Code:_____

Phone Number: _____

Do they have a Legal Guardian? YES_____NO_____

Guardian Name:_____Phone Number:_____

Who should we contact to schedule?

Name:_____Phone Number:_____

Relationship to Individual: _____

Would you like to be notified if/when the assessment is scheduled? YES_____NO_____

If you have questions, please call 567-247-6439