Ohio Department of Developmental Disabilities

Application for Intermediate Care Facilities (ICF) for ventilator services program

SECTION 1 – ICF-IID FACILITY ADDRESS, IDENTIFIERS AND BED INFORMATION

Facility Name		
Facility Address (Physical Location of ICF-IID)		
City, State, Zip Code		
Number of Licensed Beds	Facility Medicaid Provider Number (if current provider)	Application Date

SECTION 2 – PROVIDER COMPLIANCE

1	Are you currently an Ohio Medicaid certified ICF-IID?	
☐ YES		☐ NO
2	Do you agree to comply with all applicable federal and state regulations, laws and rules governing the ICF for ventilator services program for which you are applying for?	
☐ YES		☐ NO
3	Do you agree to cooperate with the DODD oversight function for the ICF for ventilator services program?	
☐ YES		☐ NO

SECTION 3 – PROVIDER SIGNATURE

OPTION (A) By my signature below, I certify that I am the owner or chief executive officer of the provider applying for the ICF for ventilator services program. I certify the information submitted on this application is accurate and complete. I agree that I will notify DODD, in writing, of any subsequent changes to the information contained in this application.	
Provider Representative Name (print or type)	Title (print or type)
Provider Representative Signature	Date of Signature

SECTION 4 – SIGNATURE OF AUTHORIZED DODD REPRESENTATIVE

Authorized DODD Representative Name (print or type)	Title (print or type)
Authorized DODD Representative Signature	Date of Signature

- By Signature of Authorized DODD Representative, the provider is now authorized as an ICF for ventilator services.

Completed applications can be submitted by any of the following means:

Scanned and emailed to CR-ICF@DODD.OHIO.GOV

Mailed to:
Ohio Department of Developmental Disabilities
Attention: Outlier Coordinator
30 E Broad St, 13th floor
Columbus, OH 43215