

Ohio Department of Aging Legislator Constituent Assistance FAX Form

Legislator:	<input type="checkbox"/> State <input type="checkbox"/> Federal
Legislator's Name:	_____
Legislative Phone Number:	_____
Legislative E-mail Address:	_____
Legislative Aide:	_____

Constituent's Name: _____ Age _____

Is the constituent a Medicaid Recipient? Yes No

Medicaid Provider Number: _____ Constituent ID: --

Case Manager: _____ Phone: _____

Constituent Phone: _____ Alternate Phone (optional): _____

E-mail Address (optional): _____

Mailing Address: _____

County of Residence: _____

Inquiry (Please attach additional sheets as necessary):

Please fax completed form to (614) 995-1049