Department of Mental Health & Addiction Services

# Residential State Supplement (RSS) Program Application

**Use the checklist to make sure your application is complete. All forms & instructions are available at www.mha.ohio.gov/RSS.**

- ☐ RSS Program Application (Pages 1 – 2)
- ☐ RSS Authorization for Release of Information
- ☐ ODM 07120 Form
- ☐ Proof of Legal Guardianship (if applicable)

**Complete RSS applications may be submitted via encrypted email to RSS@mha.ohio.gov or fax to (614) 485-9747.**

## Demographic Information

| | | |
|---|---|---|
| **Individual's Name (Last, First):** | **Date Submitted:** | |
| **Social Security Number (required):** | **Date of Birth:** | **Gender:**<br>☐ Female<br>☐ Male<br>☐ Other/Prefer Not to Respond |
| **Referral Source Name & Organization Name:** | **County of Referral:** | |
| **Relationship to Applicant:** | **Referral Source Email/Phone (required):** | |
| **Diagnosis Information, please check all that apply:**<br>☐ Mental Illness or Substance Use Disorder<br>☐ Intellectual or Developmental Disability<br>☐ Other Disability | **Legal Guardian Name & Email/Phone (if applicable):** | |
| **Applicant's Current Residence/Address:** | **Is the applicant currently**:<br><br>Receiving treatment in a nursing facility? ☐ Yes ☐ No<br>Living in a Class 2 Residential Facility (RF2)? ☐ Yes ☐ No<br>Applying for Recovery Requires a Community? ☐ Yes ☐ No | |

## Eligibility Criteria Checklist

**Check the appropriate boxes below:**

- Is the applicant age 18 or older? ☐ Yes ☐ No
- Is the applicant enrolled in Medicaid (not a waiver program)? ☐ Yes ☐ No
- Is the applicant **currently** receiving Social Security, SSI, or SSDI? ☐ Yes ☐ No

# Residential State Supplement
# Authorization for Release of Information

I, _____ [_____], hereby authorize the Ohio Department of Mental Health
*(Individual's First & Last Name)* *(Date of Birth)*
and Addiction Services (OhioMHAS) to release my Protected Health Information (PHI), Patient Identifying Information (PII), and other personal, non-public information to the individuals or agencies listed below for the purpose of facilitating my enrollment in the Residential State Supplement (RSS) Program, confirming my residence is an eligible living arrangement, assisting with my possible transition from an institution to another setting, and helping obtain local resources and services. I understand that PHI, PII, and other personal, non-public information includes, but may not be limited to, my name, social security number, date of birth, Medicaid case number, address, phone number, income type and/or amount, physical and behavioral health diagnoses, and previous or current treatment and services received.

| *Name of Agency* | *Name of Individual Contact* |
|---|---|
| Residential Facility or Residential Care Facility (**required** name here): | Facility Operator (**required** name here): |
| Representative/Protective Payee (if applicable; name of agency or individual here): | |
| Nursing Facility (if applicable; enter name of facility here): | Discharge Planner (if applicable; enter name here): |
| Ohio Department of Medicaid (ODM) and the Managed Care Plan in which I am enrolled | |
| Ohio Department of Job and Family Services (ODJFS) and County Department of Job and Family Services (no PII) | |
| Alcohol, Drug Addiction, and Mental Health (ADAMH) or Alcohol and Drug Addiction Services (ADAS) Boards | |
| Ohio Department of Aging (ODA), Area Agency/ies on Aging, State and Local Offices of the Long-Term Care Ombudsman | |
| Ohio Department of Developmental Disabilities (DODD) and/or County Boards of Developmental Disabilities | |
| Other (if applicable; enter name of individual or entity here): | |

I understand that I may not be denied treatment, payment for services, or enrollment in a health plan, but may be denied eligibility for the Residential State Supplement Program if I refuse to sign this authorization. This authorization will remain effective while I am enrolled in the program unless another date or condition/event is specified here: _____.
I understand I have the right to revoke this authorization in writing, at any time, and that the revocation will be effective except to the extent that OhioMHAS has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to: *Community Transitions c/o OhioMHAS, 30 E. Broad Street, 36th Floor, Columbus, OH, 43215*.

| Printed Name of Individual or Legal Guardian (if applicable) | Signature of Individual or Legal Guardian (if applicable) | Date Signed *(mm/dd/yyyy)* |
|---|---|---|
| | | |

If this authorization has been signed by a legal guardian on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: _____.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure except as prohibited by state and federal law. ORC 5119.27, 5119.28, 5122.31, and/or 42 CFR Part 2 may prohibit recipient from making any further disclosure of it without my specific and informed authorization for release, or as otherwise permitted by law.

**OHIO DEPARTMENT OF MEDICAID**

# Residential State Supplement (RSS) Referral for Enrollment

This is a referral for enrollment in the Residential State Supplement (RSS) program. The individual must have a completed Medicaid application and meet certain non-financial, financial, and resource requirements to be eligible for RSS.

**SECTION A** *(to be completed by the RSS Applicant or Legal Guardian)*

I, the undersigned, hereby authorize the Ohio Department of Mental Health and Addiction Services *(OhioMHAS)* as the RSS administrative agency, the Ohio Department of Medicaid (ODM), and the County Department of Job and Family Services (CDJFS) to exchange such information as necessary regarding my eligibility for RSS Cash and Medicaid assistance.

| Name of Individual or Legal Guardian *(if applicable*) | Signature of Individual or Legal Guardian *(if applicable)* | Date |
|---|---|---|
| | | |

**SECTION B** *to be completed by OhioMHAS and processed by the local CDJFS*

| **Referral Information** | | | | |
|---|---|---|---|---|
| Date of Referral to CDJFS | Applicant's Name *(Last, First)* | Social Security Number | Medicaid Case Number | |
| | | | | |
| RSS Effective Date | Living Arrangement Type<br>☒ Class Two Residential Facility *(RF2; licensed by MHAS)*<br>☐ Residential Care Facility (RCF/Assisted Living; licensed by ODH) | | | |
| | | | | |
| Facility Name | Facility Address | | | |
| | Street Address | City | State | Zip |
| | | | | |

| Facility Phone | Facility County | County Transfer *(if applicable)* |
|---|---|---|
| | | |

| **Protective Payee Information** *(if applicable; NOT Authorized Representative)* | | | |
|---|---|---|---|
| Protective Payee Name | Payee Phone Number | | |
| | | | |
| Payee Mailing Address | | | |
| Street Address | City | State | Zip |
| | | | |



**Distribution:** *Original to OhioMHAS, copy to CDJFS*

## Eligible Living Arrangement

**Provide the Eligible Living Arrangement (e.g., Class 2 Residential Facility) where the individual will live while enrolled in RSS. Include the Facility Name, Home Operator Name, Address and Contact information.**

| | |
|---|---|
| **Facility Name:** | **Address:** |
| **County:** | **Move in Date:** |
| **Contact Name:** | **Phone/Email:** |

**Please refer to the list of eligible living arrangements at [www.mha.ohio.gov/RSS](www.mha.ohio.gov/RSS).*

## Level of Care Assessment

**Please list contact information below so OhioMHAS can request a level of care (LOC) assessment. This is who your Area Aging on Agency will contact to schedule the assessment.**

| | |
|---|---|
| **Contact Name & Organization:** | **Relationship to applicant:**<br>☐ Case Manager<br>☐ Facility Operator<br>☐ Other _____ |
| **Direct line and extension/Cell (required):** | **Email:** |

**If an individual is residing in a nursing home **when the RSS application is submitted** to OhioMHAS, leave this section blank.*

## Representative Payee Information

**Will the individual have a Representative Payee for RSS benefits?** ☐ Yes ☐ No (The applicant should receive all RSS benefits directly)

**If yes, please list below.** *Do not list the nursing facility or home operator.*

| | | |
|---|---|---|
| **Representative Payee Name/Agency:** | **Address:** | **Phone/Email:** |