Promoting Wellness and Recovery

Nursing Facility Community Transition Resource Packet

The following programs were created to help people who are ready to move out of nursing homes. You or your legal guardian can fill out the forms in this packet to apply for these programs.

- **Residential State Supplement:** Can help if you are interested in living in a group home. You must be over 18 and enrolled in Medicaid. However, you cannot use it if you are on a Medicaid waiver. For more information, please go online to www.mha.ohio.gov/RSS, send an email to RSS@mha.ohio.gov, or call (614) 752-9316.

- **HOME Choice:** Can help plan and arrange for such things as housing, benefits, and other supports you may need to plan for your discharge from the nursing home, and for the first year following your return to the community. For more information, please go to www.medicaid.ohio.gov/HOMEchoice, email HOME_Choice@medicaid.ohio.gov, or call 1-888-221-1560.

- **Recovery Requires a Community:** Can include time-limited housing or utility assistance, start-up goods and services, or other recovery supports on a case-by-case basis. For more information, please go to www.mha.ohio.gov/RRAC, email Recovery@mha.ohio.gov, or call (614) 644-0617.

In this packet, you will also find a page with more information about each of these programs. If you have questions or need help applying, please contact any of the contact numbers listed above.

RESOURCES FOR COMMUNITY LIVING IN OHIO

Helping Ohioans choose housing options other than nursing homes

HOME Choice provides assistance with moving into the community. The person must be in an institutional setting at least 90 days and meet other eligibility criteria.

Some areas of assistance…

• Locating housing • Setting up a household
• Connecting to necessary goods and services

For more information or to apply

CALL (888) 221-1560

or visit online:

http://medicaid.ohio.gov/HomeChoice

The **Residential State Supplement** Program provides financial assistance to adults with disabilities who can live in eligible community housing. The person must be enrolled in Medicaid and receiving Social Security, SSI or SSDI.

The RSS benefit helps pay for . . .

• Accommodations • Supervision • Personal Care Services

For more information or to apply

CALL (614) 752-9316

or visit online:

http://mha.ohio.gov/RSS

Recovery Requires a Community assists people with a behavioral health diagnosis to move to and remain in community housing. It pays for . . .

• temporary housing or utility assistance, or goods and services

For more information or to apply

CALL (614) 644-0617

or visit online:

http://mha.ohio.gov/RRAC

HOME & COMMUNITY-BASED **WAIVERS**

Medicaid waivers allow individuals with disabilities and chronic conditions to receive care in their homes and communities rather than in long-term care facilities. These waivers also allow individuals to have more control over their care and remain active in their communities. To learn about eligibility and coverage, or to apply

CALL (800) 324-8680

or visit online:

http://medicaid.ohio.gov/FOROHIOANS/Programs/HCBSWaivers.aspx

Other helpful resources

Advocacy/Rights	800-282-1206	Department of Aging Ombudsman
Housing	614-466-7970	Housing Locator
Job Assistance	888-296-7541	Ohio Means Jobs
Legal Assistance	800-282-9181	Disability Rights Ohio
Mental Health and Addiction Services	877-275-6364	Ohio Department of Mental Health and Addiction Services County ADAMHS Board Directory
SSI/SSDI Application	614-280-1984	SSI Ohio Project

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Residential State Supplement (RSS) Program Application

Applicant Name (Last, First)		Date Submitted	
SSN		DOB	
Referral Source Name/Organization		County of Referral	
Relationship to Applicant		Referral Source Phone/Fax/Email	

1) Is the Applicant: (check the appropriate boxes)

a) Age 18 or older? ☐ **Yes** ☐ **No**

b) Enrolled in Medicaid (not a waiver program)? ☐ **Yes** ☐ **No**

c) Currently receiving Social Security, SSI, and/or SSDI? ☐ **Yes** ☐ **No**

d) Currently residing or receiving treatment in a(n) ...

☐ Nursing Home ☐ Hospital ☐ Adult Care Facility or Foster Home

☐ Other (please describe) _____

2) Where is the applicant currently residing or receiving treatment?

Name of Residence/ Treatment Setting		Address	
Contact Name		Phone/Email	

3) Does the applicant have a Legal Guardian? ☐ **Yes** ☐ **No**

If Yes, please list below:

Name/Organization	Address	Phone/Fax/Email

4) Will/Does the applicant have a Representative Payee in the community? ☐ **Yes** ☐ **No**

If Yes, please list below (do not indicate the nursing home):

Name/Organization	Address	Phone/Fax/Email

Residential State Supplement (RSS) Program Application

5) Which RSS-Elibigle Community Residence has been selected by the applicant or is where the applicant is currently living? ***(Please refer to updated listing on the RSS webpage at mha.ohio.gov.)***

Community Residence Name		**Address**	
County		**Scheduled Move Date (if applicable)**	
Contact Name		**Phone/Email**	

6) Does the applicant have a diagnosis of the following? ☐ **Yes** ☐ **No**

If YES, please list below:

a) Mental Illness	
b) Alcohol and Other Drug (AOD) Disorder	
c) Developmental/Intellectual Disability	
d) Physical Disability	

7) Does the applicant need Community-Based Services? ☐ **Yes** ☐ **No**

If YES, please indicate from which local providers the applicant currently receives or has applied for services:

	Agency Name	Case Manager Name	Phone	Email
☐ **Aging**				
☐ **AOD**				
☐ **Mental Health**				
☐ **Developmental/ Intellectual Disability**				
☐ **Other**				

Please fax the following documents to 1-614-485-9747 to complete the RSS application process:

☐ Confidential Fax Cover Sheet

☐ RSS Authorization for Release of Information

☐ Proof of Legal Guardianship (if applicable)

☐ RSS Program Application

☐ ODJFS 07120 Form

*** Only completed applications submitted correctly will be reviewed. All forms & instructions are available on the RSS webpage at mha.ohio.gov**

Residential State Supplement Authorization for Release of Information

I, _____ [_____], hereby authorize the Ohio Department of
(Individual's First & Last Name) *(Date of Birth)*
Mental Health and Addiction Services (OhioMHAS) to release my Protected Health Information (PHI) 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 and to assist with my possible transition from an institution to an integrated community setting. I understand that PHI and other personal, non-public information includes, but may not be limited to, my social security number, date of birth, address, phone number, income type and/or amount, physical or behavioral health diagnoses, and previous or current treatment and services received.

- ☒ Ohio Department of Job and Family Services (ODJFS) and County Department of Job and Family Services
- ☒ Ohio Department of Medicaid (ODM)
- ☒ Ohio Department of Aging (ODA) and Area Agencies on Aging
- ☒ Ohio Department of Developmental Disabilities (DODD) and County Boards of Developmental Disabilities
- ☒ Alcohol, Drug Addiction, and Mental Health (ADAMH) or Alcohol and Drug Addiction Services (ADAS) Boards
- ☒ Providers contracting with OhioMHAS, ODM, ODA, DODD or ADAMH/ADAS Boards
- ☐ Residential Facility Operator or Residential Care Facility Operator; **please enter name of facility and operator here:** _____
- ☐ Representative Payee (if applicable); **please enter name of individual or agency acting as payee for RSS benefits here:** _____
- ☐ Nursing Facility (if applicable); **please enter name of facility here:** _____

My refusal to sign this authorization will NOT exclude me from enrolling in the RSS program, but may impact the OhioMHAS' ability to act on my behalf in obtaining benefits and assisting with my transition to an integrated community setting. This authorization will remain effective for 365 days unless an earlier 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: _____.

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. ORC 5119.27, 5119.28, 5122.31, and/or 42 CFR Part 2 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.

Please return to Community Transitions via encrypted email to RSS@mha.ohio.gov or fax to 614-485-9747.

Instructions for the completing the

RSS Authorization for Release of Information

Please review the following instructions prior to signing the RSS Authorization for Release of Information form below. Any forms completed incorrectly will need to be resubmitted by the applicant or his/her legal guardian. Information to be completed includes:

a) *Individual's First and Last Name*

b) *Individual's Date of Birth*

c) *Residential Facility Operator or Residential Care Facility Operator (include name of facility and operator)*

d) *Representative Payee (please enter name of individual or agency acting as payee for RSS benefits)*

e) *Nursing Facility (if applicable, please enter name of nursing facility from which the individual is applying)*

f) *Complete the checkboxes authorizing release of information to Residential Facility Operator, Representative Payee, and Nursing Facility*

If the applicant has a legal guardian, then he or she should provide that information in the space provided, and sign the form.

Ohio Department of Job and Family Services

RESIDENTIAL STATE SUPPLEMENT

This is a referral for enrollment in the Residential State Supplement (RSS) Program. If you meet all the necessary requirements for enrollment and you complete an application for Medicaid, then you may be eligible for RSS.

Date of Referral to CDJFS

☐ This is to verify that the below named individual is being referred to the County Department of Job and Family Services (CDJFS) for a determination of the individual's Medicaid and RSS eligibility.

Signature of RSS Administrator or Designee	Date

☐ The below named individual has requested to be registered for enrollment in the RSS program.

Signature of CDJFS Caseworker	Unique ID	Date of Referral

The applicant should complete Section A only, then sign and date Section C. Please print legibly.

SECTION A	
Name *First* *Last*	Social Security Number
Facility Name and Street Address	Phone Number ( )
City, State, and Zip Code	County
Name and Address of Representative Payee and/or Legal Guardian	Phone Number ( )

SECTION B - This Block Must be Completed by the CDJFS	
Is the individual currently on Medicaid? ☐ Yes ☐ No	Spenddown Amount (if applicable)
MITS Claim Number	County

I. the undersigned, hereby authorize the Ohio Department of Mental Health or its designee and the CDJFS to exchange such information as necessary regarding my eligibility for Medicaid and the RSS Program.

SECTION C

Signature of Individual in need of RSS (Representative Payee and/or Legal Guardian, if applicable)	Date

NOTE: RSS financial eligibility will be determined by the CDJFS when this form has been completed and signed by the individual requesting RSS.

Instructions for completing the

ODJFS 07120

Please review the following instructions prior to completing ODJFS 07120 form below. ***Please note that the applicant should only complete Sections A & C.*** *Any forms completed incorrectly will need to be resubmitted by the applicant or his/her legal guardian.*

Section A

a) *Name:* Applicant's complete name

b) *Social Security Number*

c) *Facility Name and Street Address:* Name & street address of the RSS-eligible community residence, i.e. Adult Care Facility, Adult Foster Home, or Assisted Living Facility. Please note the nursing home should not be listed.

d) *Phone Number:* Phone number of the RSS-eligible community residence, i.e. Adult Care Facility, Adult Foster Home, or Assisted Living Facility. Please note the nursing home should not be listed.

e) *City, State, and Zip Code:* Information of the RSS-eligible community residence, i.e. Adult Care Facility, Adult Foster Home, or Assisted Living Facility. Please note the nursing home should not be listed.

f) *County:* County where the RSS-eligible community residence is located.

g) *Name and Address of Representative Payee and/or Legal Guardian:* Please note the nursing home should not be indicated as the Representative Payee on this form.

h) *Phone Number:* Please note the nursing home should not be indicated as the Representative Payee on this form.

Section C

a) *Signature of Individual in need of RSS (Representative Payee and/or Legal Guardian, if applicable):* Please note that the nursing home should not be indicated as the Representative Payee on this form.

b) *Date*

Name of Provider or Individual Assisting with Completion:	
Date *(mm/dd/yyyy):*	Phone and Email:

Recovery Requires a Community Authorization for Release of Information

I, _____ [_____], hereby authorize the Ohio Department
(Individual's First & Last Name) *(Date of Birth)*
of Mental Health and Addiction Services to release my Protected Health Information (PHI) and other personal, non-public information to the individuals or agencies listed below for the purpose of facilitating my enrollment in the Recovery Requires a Community Program and to assist with my transition from an institution to an integrated community setting. I understand that PHI and other personal, non-public information includes, but may not be limited to, my social security number, date of birth, address, phone number, income type and/or amount, physical or behavioral health diagnoses, and previous or current treatment and services received.

- Ohio Department of Medicaid (ODM)
- Alcohol, Drug Addiction, and Mental Health (ADAMH) or Alcohol and Drug Addiction Services (ADAS) Boards
- Providers contracting with OhioMHAS, ODM, ODA or ADAMH/ADAS Boards
- Ohio Department of Aging (ODA) and Area Agencies on Aging

I authorize the following information to be released to providers or agencies involved in my transition and stabilization in the community, as well as for the purpose of the evaluation of the program:

- Medicaid information, including claims data
- Helping Ohioans Move Expanding (HOME) Choice documentation
- Documentation required for Recovery Requires a Community application and enrollment
- Diagnoses or treatment for mental health or substance use disorders
- Diagnoses or treatment relating to other communicable diseases
- Pre-Admission Screening and Resident Review (PASRR) information related to institutional stay

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan. This authorization will remain effective for 365 days unless an earlier 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 and Legal Guardian (if applicable)	Signature of Individual or Legal Guardian	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: _____.

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. ORC 5119.27, 5119.28, 5122.31, and/or 42 CFR Part 2 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.

Please return to Community Transitions via encrypted email Recovery@mha.ohio.gov or fax 614-488-4504 prior to discharge from the nursing facility.

Ohio Department of Medicaid

HOME CHOICE - APPLICATION

Applicant Name *(Last, First, MI)*			Phone - Applicant
Is the applicant on Medicaid? ☐ Yes ☐ No			Medicaid ID Number *(12 digits)*
Gender ☐ M ☐ F	Date of Birth *(mm/dd/yyyy)*		County
Name of Facility		Date of Admission *(mm/dd/yyyy)*	
Street Address		Phone - Facility	
City	State	Zip Code	Fax - Facility

Referral Source

☐ Self ☐ CLS ☐ Hospital ☐ ICF/IID ☐ CIL
☐ Friend ☐ Physician ☐ Nursing Facility ☐ LTC Ombudsman ☐ PASRR
☐ Family ☐ Family & Children First Council
☐ Other *(Specify)* ☐ Community Agency *(Specify)*

Name of Person Making Referral	Phone - Person referring	Referral Date *(mm/dd/yyyy)*

Does Applicant Have Income?
☐ Yes ☐ No

Does Applicant Have a Mental Health Diagnosis? ☐ Yes ☐ No If **Yes,** specify:	If **Yes** *(to either)*, is Applicant receiving treatment?	☐ Yes ☐ No
Does Applicant Have a Drug / Alcohol Diagnosis? ☐ Yes ☐ No		

Additional Information that will assist in processing this application

The following must be filled out if applicant has a guardian or is under age 18

Name of Guardian *(if applicable)*	Type of Guardianship ☐ Person ☐ Estate ☐ Person & Estate
Address	
City, State and Zip Code	Phone - Guardian
Name of Parent *(if applicant is younger than18)*	Phone - Parent
Address	
City, State, and Zip Code	

Who else might we contact about the person being referred?	Phone - Other
Signature of Applicant or Guardian (***REQUIRED***)	Date *(mm/dd/yyyy)*

Submit this form to:

Ohio Department of Medicaid
Bureau of Long-Term Care Services and Supports
HOME Choice Operations Unit
Box 182709, 5th Floor
Columbus, Ohio 43218-2709

E-Mail: HOME_Choice@medicaid.ohio.gov Phone: (888) 221-1560 Fax: (614) 466-6945