



## Residential State Supplement (RSS) Program Application

Is the Applicant: (check the appropriate boxes)

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| a) Age 18 or older?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Enrolled in Medicaid ( <u>not</u> a waiver program)?               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Currently receiving Social Security, SSI, and/or SSDI?             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Receiving treatment & preparing for discharge from a nursing home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**PLEASE NOTE:** The answers to all of the above questions must be "YES" in order to apply to the RSS Program.

Applicant Name: (Last, First)		Date Submitted:	
SSN:		DOB:	
Referral Source Name:		County of Referral:	
Relationship to Applicant:		Referral Source Phone/Fax/Email:	
Nursing Home Name:		Nursing Home Address:	
Nursing Home Contact Name <i>(if different than Referral Source):</i>		Nursing Home Phone/Fax/Email:	

1. Does the applicant have a Legal Guardian?  Yes  No

*If YES, please list below:*

Name/Agency:	Address:	Phone/Fax/Email:
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2. Does the applicant have a Representative Payee?  Yes  No

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

Name/Agency:	Address:	Phone/Fax/Email:
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3. Which RSS-Eligible Community Residence has been selected by the applicant?

*Please refer to updated listings on the RSS webpage at [mha.ohio.gov](http://mha.ohio.gov).*

Community Residence Name:	Address:
County:	Scheduled Move Date:



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**4. Does the applicant have a diagnosis of the following?**

*If YES, please list below:*

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

**5. Does the applicant need Community-Based Services?     Yes     No**

*If YES, please list from which service systems the applicant currently receives or has applied for services:*

	Agency Name	Case Manager Name	Phone	Email
<input type="checkbox"/> Aging				
<input type="checkbox"/> AOD				
<input type="checkbox"/> Mental Health				
<input type="checkbox"/> Developmental/Intellectual Disability				
<input type="checkbox"/> Other				

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

- Confidential Fax Cover Sheet
- RSS Program Application
- RSS Authorization for Release of Information
- ODJFS 07120 Form
- Proof of Legal Guardianship (if applicable)

***\* Only completed applications submitted correctly will be reviewed. All forms & instructions are available on the RSS webpage at [mha.ohio.gov](http://mha.ohio.gov).***