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.