



*Promoting Wellness and Recovery*

# **Nursing Facility Community Transition Resource Packet**



## Promoting wellness and recovery

---

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • [mha.ohio.gov](http://mha.ohio.gov)

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 [mha.ohio.gov/RSS](http://mha.ohio.gov/RSS), send an email [RSS@mha.ohio.gov](mailto: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 [medicaid.ohio.gov/HOME Choice](http://medicaid.ohio.gov/HOME_Choice), email [HOME\\_Choice@medicaid.ohio.gov](mailto:HOME_Choice@medicaid.ohio.gov), or call 1-888-221-1560.
- **Recovery Requires a Community:** Can help to fill any gaps left beyond the help offered by the other programs listed above. For more information, please go to [mha.ohio.gov/RRAC](http://mha.ohio.gov/RRAC), email [Recovery@mha.ohio.gov](mailto:Recovery@mha.ohio.gov), or call 614-387-2799.

In this packet you will also find a page with more information about 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 diagnosed with mental illness to move to and remain in community housing. It pays for . . .



- Goods and services not covered by other funding programs

For more information or to apply

**CALL (614) 466-9985**

or visit online:

<http://mha.ohio.gov/RRAC>

There are a variety of funding programs that pay for in-home assistance, home-delivered meals, home modifications, adult day-care and other services, depending on the waiver.

HOME &  
COMMUNITY-BASED  
**WAIVERS**

To learn more about waivers, eligibility and coverage, or to apply

**CALL (800) 324-8680**

or visit online:

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

## Other helpful resources

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



## Residential State Supplement (RSS) Program Application



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

**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?**

<b>Name of Residence/ Treatment Setting</b>		<b>Address</b>	
<b>Contact Name</b>		<b>Phone/Email</b>	

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

*If Yes, please list below:*

<b>Name/Organization</b>	<b>Address</b>	<b>Phone/Fax/Email</b>

**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):*

<b>Name/Organization</b>	<b>Address</b>	<b>Phone/Fax/Email</b>



## Residential State Supplement (RSS) Program Application



5) Which RSS-Eligible 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](http://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
<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:**

- |   |  |
|---|--|
| <input type="checkbox"/> Confidential Fax Cover Sheet                 | <input type="checkbox"/> RSS Program Application |
| <input type="checkbox"/> RSS Authorization for Release of Information | <input type="checkbox"/> ODJFS 07120 Form        |
| <input type="checkbox"/> 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)**



**Residential State Supplement (RSS)**  
**Authorization for Release of Information**

I, \_\_\_\_\_, hereby authorize the Residential State Supplement (RSS) Program to release my Protected Health Information (PHI) to the individuals and/or agencies listed below for the purpose of facilitating my enrollment in the RSS Program. I understand that PHI includes, but may not be limited to, my social security number, date of birth, address, phone number, income type and/or amount, physical and/or mental health diagnoses, and previous/current treatment & services received.

Type of Contact	Individual and/or Agency Name	Phone
County Dept of Job & Family Services (CDJFS)		
Nursing Home		
Community Residence		
Case Manager (if applicable)		
Representative Payee (if applicable)		
Other (indicate relationship to RSS consumer)		

My refusal to sign this authorization will not exclude me from enrolling in the RSS Program, but may impact the RSS Administrator's ability to act on my behalf in obtaining benefits. This authorization will remain effective for 180 days unless an earlier date or condition/event is specified here: \_\_\_\_\_ . I understand that 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 ODMH/RSS has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to: *RSS Administrator, Ohio Department of Mental Health & Addiction Services, 30 East Broad Street, Columbus, Ohio, 43215.*

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

Printed Name of Individual/Legal Guardian	Signature of Individual/Legal Guardian	Date Signed

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State & Federal law. ORC 5122.31, 42 CFR Part 2, and/or ORC 3701.243 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.



---

**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 under “**Individual and/or Agency Name**” includes:*

- a) *County Dept of Job & Family Services:* County or counties (if applicant will be changing county of residence) where applicant receives Medicaid benefits
- b) *Nursing Home:* Name of the nursing home where applicant currently resides
- c) *Community Residence:* Name 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) *Case Manager:* Name of the case manager & agency, if applicable
- e) *Representative Payee:* Name of the representative payee & agency, if applicable
- f) *Other:* Name(s) of other individual(s) acting on the individual’s behalf, e.g. family members, long-term care ombudsman

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.

<b>SECTION A</b>	
Name <i>First</i> <span style="float: right;"><i>Last</i></span>	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 (    )
<b>SECTION B - This Block Must be Completed by the CDJFS</b>	
Is the individual currently on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Assisting with Completion: \_\_\_\_\_

Name of Person Assisting with Completion: \_\_\_\_\_

Date \_\_\_\_\_ Phone # \_\_\_\_\_

Email \_\_\_\_\_

## Authorization for Release of Information for Recovery Requires a Community

Please return to [Recovery@mha.ohio.gov](mailto:Recovery@mha.ohio.gov); or fax to 614.488.4504

I, \_\_\_\_\_, date of birth \_\_\_\_\_  
hereby authorize the release of my personal information to providers or agencies specifically involved in my transition and stabilization in the community, which includes:

- Ohio Department of Mental Health and Addiction Services (OhioMHAS)
- Ohio Department of Medicaid (ODM)
- Ohio County Alcohol, Drug, and Mental Health Boards (ADAMH)
- Providers contracting with OhioMHAS, ODM, and/or ADAMH

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

- Medicaid information, including claims data
- Community transition/HOME Choice documentation
- Documentation required for Recovery Requires a Community funding application
- Diagnoses and/or treatment for alcohol and/or drug abuse
- AIDS/AIDS Related Complex diagnoses and/or treatment
- HIV test results
- Diagnoses and/or treatment relating to other communicable diseases
- PASRR Information related to my time in an institution

Indicate here any additional exceptions or exclusions, if any, to information released:

This authorization for use/disclosure is for the following purpose:

**To assist with my Transition from an Institutional Setting into Community**

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, or (fill in date) \_\_\_\_\_. 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:

Name and Address:

**Office of Treatment and Recovery, 30 East Broad Street, 36<sup>th</sup> Floor, Columbus, Ohio 43215**

Signature of Individual/Guardian/Personal Representative:

Date Signed:

Print Name:

If this authorization has been signed by a personal representative 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.

Ohio Department of Medicaid  
**HOME CHOICE - APPLICATION**

Applicant Name ( <i>Last, First, MI</i> )		Phone - Applicant	
Is the applicant on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid ID # ( <i>12 digits</i> )	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ( <i>mm/dd/yyyy</i> )		County
Name of Facility		Date of Admission ( <i>mm/dd/yyyy</i> )	
Street Address		Phone - Facility	
City	State	Zip Code	Fax - Facility
Referral Source <input type="checkbox"/> Self <input type="checkbox"/> CLS <input type="checkbox"/> Hospital <input type="checkbox"/> ICF/IID <input type="checkbox"/> CIL <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Nursing Facility <input type="checkbox"/> LTC Ombudsman <input type="checkbox"/> PASRR <input type="checkbox"/> Family <input type="checkbox"/> Family & Children First Council <input type="checkbox"/> Other ( <i>Specify</i> ) <input type="checkbox"/> Community Agency ( <i>Specify</i> )			
Name of Person Making Referral		Phone - Person referring	Referral Date ( <i>mm/dd/yyyy</i> )
Does Applicant Have Income? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does Applicant Have a Mental Health Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No      If <b>Yes</b> , specify:		If <b>Yes</b> (to either), is Applicant receiving treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does Applicant Have a Drug / Alcohol Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Additional Information that will assist in processing this application</b>			
<b>The following must be filled out if applicant has a guardian or is under age 18</b>			
Name of Guardian ( <i>if applicable</i> )		Type of Guardianship <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Person & Estate	
Address			
City, State and Zip Code		Phone - Guardian	
Name of Parent ( <i>if applicant is younger than 18</i> )		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 ( <b>REQUIRED</b> )			Date ( <i>mm/dd/yyyy</i> )

**Submit this form to:**  
HOME Choice Operations Unit  
Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports  
Box 182709, 5<sup>th</sup> Floor  
Columbus, Ohio 43218-2709  
E-Mail: HOME\_Choice@medicaid.ohio.gov   Phone: (888) 221-1560   Fax: (614) 466-6945