



## Residential State Supplement (RSS) Program Application



Please send the following documents via encrypted e-mail to [RSS@mha.ohio.gov](mailto:RSS@mha.ohio.gov) or fax to (614) 485-9747 to complete the RSS application process:

- 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 online at [www.mha.ohio.gov/RSS](http://www.mha.ohio.gov/RSS)

### Demographic Information

<b>Individual's Name (Last, First):</b>	<b>Date Submitted:</b>	
<b>Social Security Number:</b>	<b>Date of Birth:</b>	<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other/Prefer Not to Respond
<b>Referral Source Name &amp; Organization Name:</b>	<b>County of Referral:</b>	
<b>Relationship to Applicant:</b>	<b>Referral Source Contact, Email/Phone/Fax:</b>	
<b>Diagnosis Information, please check all that apply:</b> <input type="checkbox"/> Mental Illness <input type="checkbox"/> Alcohol or Other Drug (AoD) Disorder <input type="checkbox"/> Intellectual/Development Disorder <input type="checkbox"/> Other Disability	<b>Legal Guardian Name, Address and Email/Phone/Fax (if applicable):</b>	
<b>Applicant's Current Residence/Address:</b>	<b>Is the applicant currently:</b>  Receiving treatment in a nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No Residing in a Residential Facility (Class Two)? <input type="checkbox"/> Yes <input type="checkbox"/> No Applying for Recovery Requires a Community? <input type="checkbox"/> Yes <input type="checkbox"/> No Participating in HOME Choice? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Eligibility Criteria Checklist

Check the appropriate boxes below.

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| ▪ Is the applicant age 18 or older?                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Is the applicant enrolled in Medicaid ( <u>not</u> a waiver program)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Is the applicant Currently receiving Social Security, SSI, or SSDI?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ May the applicant meet a Protective Level of Care?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## RSS Eligible Living Arrangement

Provide the Eligible Living Arrangement (e.g. Residential Facility Class 2) where the individual will reside while enrolled on the RSS program. Include the Facility Name, Home Operator Name, Address and Contact information below:

<b>Name of Residence:</b>	<b>Address:</b>
<b>County:</b>	<b>Move in Date:</b>
<b>Contact Name:</b>	<b>Phone/Email:</b>

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

## Representative Payee Information

Will the individual have a Representative Payee for RSS benefits?  Yes  No (If no, the individual will receive RSS benefits directly at the eligible living arrangement)

*If yes, please list below. Do not indicate the nursing facility or the operator of the eligible living arrangement. The information below should match the Representative Payee Information on the ODJFS 07120 Form.*

<b>Name of Representative Payee/Agency:</b>	<b>Address:</b>	<b>Email/Phone/Fax</b>