



## 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>



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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).)

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

6) Does the applicant have a diagnosis of the following?  Yes  No  
*If YES, please list below:*

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

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)**