



OPTIONAL STATE SUPPLEMENTATION^[47]

SEC. 1616. [42 U.S.C. 1382e] (a) Any cash payments which are made by a State (or political subdivision thereof) on a regular basis to individuals who are receiving benefits under this title or who would but for their income be eligible to receive benefits under this title, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), shall be excluded under section 1612(b)(6) in determining the income of such individuals for purposes of this title and the Commissioner of Social Security and such State may enter into an agreement which satisfies subsection (b) under which the Commissioner of Social Security will, on behalf of such State (or subdivision) make such supplementary payments to all such individuals.

(b) Any agreement between the Commissioner of Social Security and a State entered into under subsection (a) shall provide—

(1) that such payments will be made (subject to subsection (c)) to all individuals residing in such State (or subdivision) who are receiving benefits under this title, and

(2) such other rules with respect to eligibility for or amount of the supplementary payments, and such procedural or other general administrative provisions, as the Commissioner of Social Security finds necessary (subject to subsection (c)) to achieve efficient and effective administration of both the program which the Commissioner conducts under this title and the optional State supplementation.

At the option of the State (but subject to paragraph (2) of this subsection), the agreement between the Commissioner of Social Security and such State entered into under subsection (a) shall be modified to provide that the Commissioner of Social Security will make supplementary payments, on and after an effective date to be specified in the agreement as so modified, to individuals receiving benefits determined under section 1611(e)(1)(B).

(c)(1) Any State (or political subdivision) making supplementary payments described in subsection (a) may at its option impose as a condition of eligibility for such payments, and include in the State's agreement with the Commissioner of Social Security under such subsection, a residence requirement which excludes individuals who have resided in the State (or political subdivision) for less than a minimum period prior to application for such payments.

(2) Any State (or political subdivision), in determining the eligibility of any individual for supplementary payments described in subsection (a), may disregard amounts of earned and unearned income in addition to other amounts which it is required or permitted to disregard under this section in determining such eligibility, and shall include a provision specifying the amount of any such income that will be disregarded, if any.

(3) Any State (or political subdivision) making supplementary payments described in subsection (a) shall have the option of making such payments to individuals who receive benefits under this title under the provisions of section 1619, or who would be eligible to receive such benefits but for their income.^[48]

(d)(1) Any State which has entered into an agreement with the Commissioner of Social Security under this section which provides that the Commissioner of Social Security will, on behalf of the State (or political subdivision), make the supplementary payments to individuals who are receiving benefits under this title (or who would but for their income be eligible to receive such benefits), shall, in accordance with paragraph (5)^[49], pay to the Commissioner of Social Security an amount equal to the expenditures made by the Commissioner of Social Security as such supplementary payments, plus an administration fee assessed in accordance with paragraph (2) and any additional services fee charged in accordance with paragraph (3).

(2)(A) The Commissioner of Social Security shall assess each State an administration fee in an amount equal to—

- (i) the number of supplementary payments made by the Commissioner of Social Security on behalf of the State under this section for any month in a fiscal year; multiplied by
- (ii) the applicable rate for the fiscal year.

(B) As used in subparagraph (A), the term “applicable rate” means—

- (i) for fiscal year 1994, \$1.67;
- (ii) for fiscal year 1995, \$3.33;
- (iii) for fiscal year 1996, \$5.00;
- (iv) for fiscal year 1997, \$5.00;
- (v) for fiscal year 1998, \$6.20;
- (vi) for fiscal year 1999, \$7.60;
- (vii) for fiscal year 2000, \$7.80;
- (viii) for fiscal year 2001, \$8.10;
- (ix) for fiscal year 2002, \$8.50; and
- (x) for fiscal year 2003 and each succeeding fiscal year—

(I) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

(II) such different rate as the Commissioner determines is appropriate for the State.

(C) Upon making a determination under subparagraph (B)(x)(II), the Commissioner of Social Security shall promulgate the determination in regulations, which may take into account the complexity of administering the State’s supplementary payment program.

(D) All fees assessed pursuant to this paragraph shall be transferred to the Commissioner of Social Security at the same time that amounts for such supplementary payments are required to be so transferred.

(3)(A) The Commissioner of Social Security may charge a State an additional services fee if, at the request of the State, the Commissioner of Social Security provides additional services beyond the level customarily provided, in the administration of State supplementary payments pursuant to this section.

(B) The additional services fee shall be in an amount that the Commissioner of Social Security determines is necessary to cover all costs (including indirect costs) incurred by the Federal Government in furnishing the additional services referred to in subparagraph (A).

(4)(A) The first \$5 of each administration fee assessed pursuant to paragraph (2), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

(B) That portion of each administration fee in excess of \$5, and 100 percent of each additional services fee charged pursuant to paragraph (3), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this title and related laws.^[50]

(5)(A)(i) Any State which has entered into an agreement with the Commissioner of Social Security under this section shall remit the payments and fees required under

this subsection with respect to monthly benefits paid to individuals under this title no later than—

(I) the business day preceding the date that the Commissioner pays such monthly benefits; or

(II) with respect to such monthly benefits paid for the month that is the last month of the State's fiscal year, the fifth business day following such date.

(ii) The Commissioner may charge States a penalty in an amount equal to 5 percent of the payment and the fees due if the remittance is received after the date required by clause (i).

(B) The Cash Management Improvement Act of 1990 shall not apply to any payments or fees required under this subsection that are paid by a State before the date required by subparagraph (A)(i).

(C) Notwithstanding subparagraph (A)(i), the Commissioner may make supplementary payments on behalf of a State with funds appropriated for payment of benefits under this title, and subsequently to be reimbursed for such payments by the State at such times as the Commissioner and State may agree. Such authority may be exercised only if extraordinary circumstances affecting a State's ability to make payment when required by subparagraph (A)(i) are determined by the Commissioner to exist.

(e)(1) Each State shall establish or designate one or more State or local authorities which shall establish, maintain, and insure the enforcement of standards for any category of institutions, foster homes, or group living arrangements in which (as determined by the State) a significant number of recipients of supplemental security income benefits is residing or is likely to reside. Such standards shall be appropriate to the needs of such recipients and the character of the facilities involved, and shall govern such matters as admission policies, safety, sanitation, and protection of civil rights.

(2) Each State shall annually make available for public review a summary of the standards established pursuant to paragraph (1), and shall make available to any interested individual a copy of such standards, along with the procedures available in the State to insure the enforcement of such standards and a list of any waivers of such standards and any violations of such standards which have come to the attention of the authority responsible for their enforcement.

(3) Each State shall certify annually to the Commissioner of Social Security that it is in compliance with the requirements of this subsection.

(4) Payments made under this title with respect to an individual shall be reduced by an amount equal to the amount of any supplementary payment (as described in subsection (a)) or other payment made by a State (or political subdivision thereof) which is made for or on account of any medical or any other type of remedial care provided by an institution of the type described in paragraph (1) to such individual as a resident or an inpatient of such institution if such institution is not approved as meeting the standards described in such paragraph by the appropriate State or local authorities.

[47] See Vol. II, P.L. 93-233, §8, with respect to the eligibility of supplemental security recipients to increases to include the bonus value of certain benefits.

[48] See Vol. II, P.L. 96-265, §201(e), with respect to the maintenance of separate accounts.

[49] See Vol. II, P.L. 92-603, §401(d), with respect to phaseout of the hold harmless provision.

[50] See Vol. II, P.L. 105-78, §516(b)(2), with respect to limitations on authorization of appropriations.



OPERATION OF STATE SUPPLEMENTATION PROGRAMS

SEC. 1618. [42 U.S.C. 1382g] (a) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66^[53]), on or after June 30, 1977, to be eligible for payments pursuant to title XIX with respect to expenditures for any calendar quarter which begins—

(1) after June 30, 1977, or, if later,
(2) after the calendar quarter in which it first makes such supplementary payments, such State must have in effect an agreement with the Commissioner of Social Security whereby the State will—

(3) continue to make such supplementary payments, and

(4) maintain such supplementary payments at levels which are not lower than the levels of such payments in effect in December 1976, or, if no such payments were made in that month, the levels for the first subsequent month in which such payments were made.

(b)(1) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for a particular month or months if the State's expenditures for such payments in the twelve-month period (within which such month or months fall) beginning on the effective date of any increase in the level of supplemental security income benefits pursuant to section 1617 are not less than its expenditures for such payments in the preceding twelve-month period.

(2) For purposes of determining under paragraph (1) whether a State's expenditures for supplementary payments in the 12-month period beginning on the effective date of any increase in the level of supplemental security income benefits are not less than the State's expenditures for such payments in the preceding 12-month period, the Commissioner of Social Security, in computing the State's expenditures, shall disregard, pursuant to a 1-time election of the State, all expenditures by the State for retroactive supplementary payments that are required to be made in connection with the retroactive supplemental security income benefits referred to in section 5041 of the Omnibus Budget Reconciliation Act of 1990^[54].

(c) Any State which satisfies the requirements of this section solely by reason of subsection (b) for a particular month or months in any 12-month period (described in such subsection) ending on or after June 30, 1982, may elect, with respect to any month in any subsequent 12-month period (so described), to apply subsection (a)(4) as though the reference to December 1976 in such subsection were a reference to the month of December which occurred in the 12-month period immediately preceding such subsequent period.

(d) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for any portion of the period July 1, 1980, through June 30, 1981, if the State's expenditures for such payments in that twelve-month period were not less than its expenditures for such payments for the period July 1, 1976, through June 30, 1977 (or, if the State made no supplementary payments in the period July 1, 1976, through June 30, 1977, the expenditures for the first twelve-month period extending from July 1 through June 30 in which the State made such payments).

(e)(1) For any particular month after March 1983, a State which is not treated as meeting the requirements imposed by paragraph (4) of subsection (a) by reason of subsection (b) shall be treated as meeting such requirements if and only if—

(A) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66^[55], for that particular month,

is not less than—

(B) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66^[56], for March 1983, increased by the amount of all cost-of-living adjustments under section 1617 (and any other benefit increases under this title) which have occurred after March 1983 and before that particular month.

(2) In determining the amount of any increase in the combined level involved under paragraph (1)(B) of this subsection, any portion of such amount which would otherwise be attributable to the increase under section 1617(c) shall be deemed instead to be equal to the amount of the cost-of-living adjustment which would have occurred in July 1983 (without regard to the 3-percent limitation contained in section 215(i)(1)(B)) if section 111 of the Social Security Amendments of 1983^[57] had not been enacted.

(f) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by subsection (a) with respect to the levels of its supplementary payments for the period January 1, 1984, through December 31, 1985, if in the period January 1, 1986, through December 31, 1986, its supplementary payment levels (other than to recipients of benefits determined under section 1611(e)(1)(B)) are not less than those in effect in December 1976, increased by a percentage equal to the percentage by which payments under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66 have been increased as a result of all adjustments under section 1617(a) and (c) which have occurred after December 1976 and before February 1986.

(g) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66^[58]) to recipients of benefits determined under section 1611(e)(1)(B), on or after October 1, 1987, to be eligible for payments pursuant to title XIX with respect to any calendar quarter which begins—

(1) after October 1, 1987, or, if later

(2) after the calendar quarter in which it first makes such supplementary payments to recipients of benefits so determined,

such State must have in effect an agreement with the Commissioner of Social Security whereby the State will—

(3) continue to make such supplementary payments to recipients of benefits so determined, and

(4) maintain such supplementary payments to recipients of benefits so determined at levels which assure (with respect to any particular month beginning with the month in which this subsection is first effective) that—

(A) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for that particular month,

is not less than—

(B) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for October 1987 (or, if no such supplementary payments were made for that month, the combined level for the first subsequent month for which such payments were made), increased—

(i) in a case to which clause (i) of such section 1611(e)(1)(B) applies or (with respect to the individual or spouse who is in the hospital, home, or facility involved) to which clause (ii) of such section applies, by \$5, and
(ii) in a case to which clause (iii) of such section 1611(e)(1)(B) applies, by \$10.

[53] See Vol. II, P.L. 93-66, §212(a).

[54] P.L. 101-508.

[55] See Vol. II, P.L. 93-66, §211(a)(1)(A).

[56] See Vol. II, P.L. 93-66, §211(a)(1)(A).

[57] P.L. 98-21.

[58] See Vol. II, P.L. 93-66, §212(a).

5119.69 [See notes for effective dates] Residential state supplement program.

(A) As used in this section and section 5119.691 of the Revised Code:

(1) "Long-term care consultation program" means the program the department of aging is required to develop under section 173.42 of the Revised Code.

(2) "Long-term care consultation program administrator" or "administrator" means the department of aging or, if the department contracts with an area agency on aging or other entity to administer the long-term care consultation program for a particular area, that agency or entity.

(3) "Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

(4) "Residential state supplement administrative agency" means the department of mental health or, if the department designates an entity under division (C) of this section for a particular area, the designated entity.

(5) "Residential state supplement program" means the program administered pursuant to this section.

(B) The department of mental health shall implement the residential state supplement program under which the state supplements the supplemental security income payments received by aged, blind, or disabled adults under Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A., as amended. Residential state supplement payments shall be used for the provision of accommodations, supervision, and personal care services to supplemental security income recipients who the department determines are at risk of needing institutional care.

(C) In implementing the program, the department may designate one or more entities to be responsible for providing administrative services regarding the program. The department may designate an entity to be a residential state supplement administrative agency under this division either by entering into a contract with the entity to serve in that capacity or by otherwise delegating to the entity the responsibility to serve in that capacity.

(D) For an individual to be eligible for residential state supplement payments, all of the following must be the case:

(1) Except as provided by division (H) of this section, the individual must reside in one of the following:

(a) A home or facility, other than a nursing home or nursing home unit of a home for the aging, licensed by the department of health under Chapter 3721. of the Revised Code ;

(b) A residential facility as defined in division (A) (9)(b) of section 5119.22 of the Revised Code licensed by the department of mental health;

(c) An apartment or room used to provide community mental health housing services certified by the department of mental health under section 5119.611 of the Revised Code and approved by a board of alcohol, drug addiction, and mental health services under division (A)(14) of section 340.03 of the Revised Code.

(2) A residential state supplement administrative agency must have determined that the environment in which the individual will be living while receiving the payments is appropriate for the individual's

needs. If the individual is eligible for supplemental security income payments or social security disability insurance benefits because of a mental disability, the residential state supplement administrative agency shall refer the individual to a community mental health agency for an assessment under division (A) of section 340.091 of the Revised Code .

(3) The individual satisfies all eligibility requirements established by rules adopted under division (E) of this section.

(E) The directors of mental health and job and family services shall adopt rules in accordance with section 111.15 of the Revised Code as necessary to implement the residential state supplement program.

To the extent permitted by Title XVI of the "Social Security Act," and any other provision of federal law, the director of job and family services may adopt rules establishing standards for adjusting the eligibility requirements concerning the level of impairment a person must have so that the amount appropriated for the program by the general assembly is adequate for the number of eligible individuals. The rules shall not limit the eligibility of disabled persons solely on a basis classifying disabilities as physical or mental. The director of job and family services also may adopt rules that establish eligibility standards for aged, blind, or disabled individuals who reside in one of the homes or facilities specified in division (D)(1) of this section but who, because of their income, do not receive supplemental security income payments. The rules may provide that these individuals may include individuals who receive other types of benefits, including, social security disability insurance benefits provided under Title II of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 401, as amended. Notwithstanding division (B) of this section, such payments may be made if funds are available for them.

The director of mental health may adopt rules establishing the method to be used to determine the amount an eligible individual will receive under the program. The amount the general assembly appropriates for the program may be a factor included in the method that director establishes.

(F) The county department of job and family services of the county in which an applicant for the residential state supplement program resides shall determine whether the applicant meets income and resource requirements for the program.

(G) The department of mental health shall maintain a waiting list of any individuals eligible for payments under this section but not receiving them because moneys appropriated to the department for the purposes of this section are insufficient to make payments to all eligible individuals. An individual may apply to be placed on the waiting list even though the individual does not reside in one of the homes or facilities specified in division (D)(1) of this section at the time of application. The director of mental health, by rules adopted in accordance with Chapter 119. of the Revised Code, may specify procedures and requirements for placing an individual on the waiting list and priorities for the order in which individuals placed on the waiting list are to begin to receive residential state supplement payments. The rules specifying priorities may give priority to individuals placed on the waiting list on or after July 1, 2006, who receive supplemental security income benefits under Title XVI of the "Social Security Act," 86 Stat. 1475 (1972), 42 U.S.C. 1381, as amended. The rules shall not affect the place on the waiting list of any person who was on the list on July 1, 2006. The rules specifying priorities may also set additional priorities based on living arrangement, such as whether an individual resides in a facility listed in division (D)(1) of this section or has been admitted to a nursing facility.

(H) An individual in a licensed or certified living arrangement receiving state supplementation on November 15, 1990, under former section 5101.531 of the Revised Code shall not become ineligible

for payments under this section solely by reason of the individual's living arrangement as long as the individual remains in the living arrangement in which the individual resided on November 15, 1990.

(I) The department of mental health shall notify each person denied approval for payments under this section of the person's right to a hearing. On request, the hearing shall be provided in accordance with Chapter 119. of the Revised Code.

Amended by 129th General Assembly File No.127, HB 487, §101.01, eff. 6/11/2012, and 9/10/2012.

Amended by 129th General Assembly File No.28, HB 153, §101.01, eff. 7/1/2011.

Amended and renumbered by 129th General Assembly File No.28, HB 153, §101.01, eff. 7/1/2011.

5119.691 Residential state supplement program patient determination.

On a periodic schedule determined by the department of mental health, each residential state supplement administrative agency shall determine whether individuals who reside in the area that the agency serves and are on a waiting list for the residential state supplement program have been admitted to a nursing facility. If a residential state supplement administrative agency determines that such an individual has been admitted to a nursing facility, the agency shall notify the long-term care consultation program administrator serving the area in which the individual resides about the determination. The administrator shall determine whether the residential state supplement program is appropriate for the individual and whether the individual would rather participate in the program than continue residing in the nursing facility. If the administrator determines that the residential state supplement program is appropriate for the individual and the individual would rather participate in the program than continue residing in the nursing facility, the administrator shall so notify the department of mental health. On receipt of the notice from the administrator, the department of mental health shall approve the individual's enrollment in the residential state supplement program in accordance with the priorities specified in rules adopted under division (G) of section 5119.69 of the Revised Code. Each quarter, the department of mental health shall certify to the director of budget and management the estimated increase in costs of the residential state supplement program resulting from enrollment of individuals in the program pursuant to this section.

Amended by 129th General Assembly File No. 127, HB 487, §101.01, eff. 6/11/2012.

Amended by 129th General Assembly File No. 28, HB 153, §101.01, eff. 7/1/2011.

Amended and renumbered by 129th General Assembly File No. 28, HB 153, §101.01, eff. 7/1/2011.

Chapter 5122-36 Residential State Supplement Program

5122-36-01 Introduction and definitions.

(A) Introduction: This chapter governs the RSS program. (The Ohio department of job and family services has also adopted rules governing this program, which are primarily located in Chapter 5101:1-17 of the Administrative Code.)

(B) Definitions for this chapter:

(1) "CDJFS" means "county department of job and family services."

(2) "Living arrangement" means an arrangement listed under division (C)(1) of section 5119.69 of the Revised Code. "Living arrangement" includes any owner, operator, employee, or volunteer who provides accommodations, supervision, or personal care services in the living arrangement.

(3) ODMH means "the Ohio department of mental health."

(4) "ODMH's designee" has the same meaning as "PASSPORT administrative agency" in section 5119.69 of the Revised Code. The current PASSPORT administrative agencies are the area agencies on aging listed in rule 173-2-04 of the Administrative Code plus "Catholic Social Services of the Miami Valley."

(5) "Resident" means an individual who is enrolled in the RSS program.

(6) "Residential State Supplement Program" ("RSS program") means the program described under section 5119.69 of the Revised Code.

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5122-36-02 Eligibility criteria.

(A) Only an individual who meets all of the following criteria is eligible for the RSS program:

(1) The individual resides in Ohio, pursuant to section 1616(b)(1) of the "Social Security Act," 49 Stat. 620 (1935), 42 USC 1382e, as amended;

(2) Pursuant to division (C)(1) of section 5119.69 of the Revised Code, the individual shall agree to reside in one of the following living arrangements and the individual is not related to an owner of the living arrangement or a caregiver in the living arrangement:

(a) An adult foster home certified under section 5119.692 of the Revised Code;

(b) A home or facility, other than a nursing home or nursing home unit of a home for the aging, licensed by the department of health under Chapter 3721. of the Revised Code or the department of mental health under sections 5119.70 to 5119.88 of the Revised Code;

(c) An apartment or room that is used to provide community mental health housing services, is certified by the Ohio department of mental health under section 5119.611 of the Revised Code, and is approved by a board of alcohol, drug addiction, and mental health services in accordance with division (A)(14) of section 340.03 of the Revised Code;

(d) A residential facility of the type defined in division (A)(1)(d)(ii) of section 5119.22 of the Revised Code, that is licensed by the Ohio department of mental health.

(3) The individual shall cooperate in the enrollment process, including applying for medicaid and selecting a living arrangement that ODMH's designee determines meets the individual's needs under paragraph (C)(5) of rule 5122-36-03 of the Administrative Code;

(4) A CDJFS determined that the individual is financially eligible for medicaid in accordance with rule 5101:1-17-04 of the Administrative Code. A CDFJS uses a "financial needs standard" ("FNS") to determine if the individual is eligible for the program;

(5) The individual needs at least a protective level of care as defined in rule 5101:3-3-08 of the Administrative Code. An individual who is receiving (or authorized for) medicaid vendor payment of the nursing facility stay and is being discharged from a nursing facility as defined in rule 5101:3-3-15 of the Administrative Code shall be determined to meet this requirement without the need for an additional level of care assessment;

(6) The individual does not require more than one hundred twenty days of skilled nursing care during any twelve-month period, unless he or she resides in a licensed residential care facility that is authorized to provide skilled nursing care under section 3721.011 of the Revised Code. "Skilled nursing care" has the same meaning as in section 3721.01 of the Revised Code;

(7) The individual does not have a cognitive impairment that requires the presence of another person on a twenty-four-hours-per-day basis for the purpose of supervision to prevent harm;

(8) The individual is not a consumer of any home and community-based waiver program;

(9) The individual is not a participant in the program of all-inclusive care for the elderly ("PACE");

(10) The individual is at least eighteen years of age; and

(11) The individual agrees to participate in the RSS program and has signed the RSS resident agreement/release of information form .

(B) If, at any time, a resident no longer meets all the criteria under paragraph (A) of this rule, the resident is no longer eligible for the RSS program, unless, according to division (G) of section 5119.69 of the Revised Code (as first enacted by Am. Sub. House Bill 253 of the 118th General Assembly), the resident no longer meets all the criteria under paragraph (A) of this rule solely by reason of his or her living arrangement, so long as he or she has continued to reside in the same living arrangement since November 15, 1990.

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5122-36-03 Enrollment process.

(A) Initial enrollment process:

(1) To request consideration to enroll in the RSS program, an individual shall submit a request to ODMH's designee or a CDJFS shall refer the individual to ODMH's designee in accordance with Chapter 5101:1-17 of the Administrative Code.

(2) Family enrollment option: If an individual and one or more members of the individual's immediate family apply for the RSS program, they may elect, at the date of request for consideration, to be considered as one individual in the enrollment process.

(3) ODMH's designee shall record the following information about the individual:

(a) The date of the request made in paragraph (A)(1) of this rule, which is the date of request for consideration;

(b) The individual's name, address, telephone number, date of birth, and social security number;

(c) If the individual has an authorized representative, the authorized representative's name, address, and telephone number. "Authorized representative" has the same meaning as in rule 5101:1-37-01 of the Administrative Code;

(d) If the individual has a legal representative, the legal representative's name, address, and telephone number. "Legal representative" means a person that the individual or probate court designates to decide for the individual. Examples of types of legal representatives are guardians, conservators, and attorneys-in-fact who are designated through a power of attorney, including a durable power of attorney for health care decisions; and,

(e) Whether the individual receives SSI benefits.

(4) ODMH's designee shall assess the individual to determine if the individual meets all the non-financial program eligibility criteria in rule 5122-36-02 of the Administrative Code.

(5) If the individual meets all the non-financial eligibility criteria for the RSS program, ODMH's designee shall add the individual to the waiting list.

(6) ODMH's designee shall allow any individual to withdraw from the waiting list at any time.

(B) Removing individuals from the waiting list:

(1) ODMH's designee shall offer enrollment to any individual on the waiting list who meets the requirements for enrollment described in paragraph (C) of this rule in the following order:

(a) First: An individual who currently resides in a nursing facility and is currently receiving SSI benefits.

(b) Second: An individual who currently resides in a nursing facility but is not currently receiving SSI benefits.

(c) Third: An individual who is currently receiving SSI benefits.

(d) Fourth: Any other individual on the waiting list.

(2) If more than one individual is waiting in a category described in paragraphs (B)(1)(a) to (B)(1)(d) of this rule, ODMH's designee shall first remove the individual with the earliest date of request for consideration.

(3) Pursuant to division (F) of section 5119.69 of the Revised Code, this rule shall not affect the place on the waiting list of any person who was on the list on July 1, 2006.

(4) Family enrollment option:

(a) If the individual chooses the family enrollment option described in paragraph (A)(2) of this rule, when the first immediate family member is selected for RSS enrollment, the ODMH's designee shall consider the other immediate family members for enrollment in the RSS program. In such cases, when immediate family members are enrolled into the RSS program as a group, ODMH's designee shall consider each immediate family member individually for the purposes of counting the maximum number of residents assigned to ODMH's designee.

(b) In order to allow immediate family members to enroll in RSS at the same time, the maximum number authorized for that region may be temporarily exceeded if the immediate family members are otherwise eligible. The number of future residents shall be reduced by the number of residents by which the maximum was exceeded for this purpose.

(5) Nursing facility: If an individual on the waiting list has been admitted to a nursing facility, ODMH's designee shall ensure that a long-term care consultation is provided to the individual, pursuant to section 173.42 of the Revised Code.

(C) Completion of the enrollment process:

(1) Contact applicant: ODMH's designee shall contact the applicant. If ODMH's designee cannot make contact with the applicant selected under paragraph (B) of this rule over the course of ten working days, ODMH's designee shall no longer consider the applicant for the RSS program unless the applicant applies for the RSS program again. If ODMH's designee is no longer considering the applicant for the RSS program, in accordance with this paragraph, ODMH's designee shall select another applicant from the waiting list, in accordance with paragraph (B) of this rule.

(2) Non-financial eligibility criteria: ODMH's designee shall determine if the applicant continues to meet the eligibility criteria of rule 5122-36-02 of the Administrative Code. If the applicant no longer meets the eligibility criteria, ODMH's designee shall deny the applicant enrollment into the RSS program.

(3) Financial eligibility criteria: ODMH's designee shall complete form JFS 07120 ("Residential State Supplement") for the applicant and submit it to a CDJFS, in accordance with Chapter 5101:1-17 of the Administrative Code to verify if the CDJFS determined that the applicant meets the medicaid financial eligibility criteria. If the applicant does not meet the financial eligibility criteria, ODMH's designee shall deny the applicant enrollment into the RSS program.

(4) Appropriateness of living arrangement:

(a) ODMH's designee shall help the applicant to locate and choose an available living arrangement in any Ohio county, then determine if the living arrangement is appropriate for the applicant according to paragraph (C)(4)(b) of this rule.

- (b) A living arrangement is only appropriate for an applicant if:
- (i) The living arrangement is able to furnish the services according to the consumer's preferences and needs that ODMH's designee identified in its assessment of the consumer;
 - (ii) The applicant, ODMH's designee, and the living arrangement agree that the living arrangement is able to furnish the services the applicant requires and is able to reach an agreement on how to pay for those services;
 - (iii) The living arrangement is one of the types of living arrangements listed under division (C)(1) of section 5119.69 of the Revised Code;
 - (iv) The living arrangement has a current, valid license or certification to operate according to its type. (e.g., If the living arrangement is an adult foster home, it has a current, valid certification from ODMH to operate.);
 - (v) No licensure or certification agency has sanctioned the living arrangement so that it shall not admit new applicants;
 - (vi) The living arrangement agrees in writing to comply with all applicable statutes and regulations governing the services that it shall furnish each resident, including the regulations in rule 5122-36-04 of the Administrative Code; and,
 - (vii) If ODMH's designee is required to consult with the mental health reviewing agency of the county in which the applicant's chosen living arrangement is located determines, the mental health reviewing agency recommends that that ODMH's designee determine that the living arrangement is appropriate.
- (a) ODMH's designee shall consult with the mental health reviewing agency no later than ten days after the applicant selects the living arrangement if the applicant has a history of receiving mental health services; or is eligible for supplemental security income (SSI) or social security disability insurance (SSDI) because of a mental disability, but does not have a primary diagnosis of dementia, delirium, Alzheimer's disease, or any other cognitive disorder defined in DSM-IV.
- (b) ODMH's designee shall supply the mental health reviewing agency with any written referral or recommendation form or any information about the applicant that it requires.
- (c) If ODMH's designee determines that the living arrangement is not appropriate, it shall:
- (i) Notify the applicant of the rationale;
 - (ii) Notify the mental health reviewing agency of the rationale if ODMH's designee consulted with a mental health reviewing agency under paragraph (C)(4)(b)(vii) of this rule; and,
 - (iii) Help the applicant locate and choose another living arrangement that is capable of meeting his or her needs.
- (d) If ODMH's designee notifies an applicant that the living arrangement he or she selected is not appropriate, but the applicant is not interested in another living arrangement, ODMH's designee shall not complete the applicant's enrollment into the program and shall inform the applicant of his or her hearing rights according to paragraph (D) of this rule.
- (5) Failure to cooperate: ODMH's designee may deny an applicant's enrollment into the RSS program if the applicant fails to cooperate in the enrollment process because:

(a) The applicant did not apply for medicaid before the tenth working day after the date of the determination in paragraph (C)(2) of this rule; or,

(b) The applicant did not select a living arrangement for a determination of the living arrangement's appropriateness, in accordance with paragraph (C)(4) of this rule, before the thirtieth day after the date of the determination in paragraph (C)(2) of this rule.

(D) Hearing rights:

(1) If ODMH's designee determines that an applicant is ineligible for the RSS program, the CDJFS shall notify the applicant of the right to a hearing, pursuant to division (H) of section 5119.69 of the Revised Code.

(2) If ODMH's designee determines that a resident is no longer eligible for the RSS program in accordance with paragraph (B) of rule 5122-36-02 of the Administrative Code, the CDJFS shall notify the resident of the disenrollment and right to a hearing, pursuant to division (H) of section 5119.69 of the Revised Code.

(E) Definitions for this rule:

(1) "Immediate family member" means the applicant's spouse, child, step-child, daughter-in-law, or son-in-law.

(2) "Mental health reviewing agency" means a mental health agency under contract with a mental health board under section 340.091 of the Revised Code to recommend if ODMH's designee should determine that a specific living arrangement is appropriate to meet a specific applicant's needs.

Effective: 02/17/2012

R.C. 119.032 review dates: 11/30/2011 and 02/17/2017

Promulgated Under: 119.03

Statutory Authority: 5119.69, Section 1616(B)(2) of the Social Security Act

Rule Amplifies: 5119.69

Prior Effective Dates: 173-35-03: 11-1-1993 (Emer.), 1-30-1994, 5-1-1994 (Emer.), 7-24-1994, 7-1-1995 (Emer.), 10-2-1995 (Emer.), 12-30-1995, 1-2-1998, 7-1-2000, 9-29-2002, 1-1-2008. 173-35-05.1: 7-1-2000, 9-29-2002, 3-7-2011

5122-36-04 Responsibilities of the living arrangement.

Each living arrangement housing a RSS resident shall:

(A) Furnish accommodations to each resident. "Accommodations" means housing, three nutritious meals per day, meal preparation, laundry service, housekeeping, arranging transportation, social activities within the living arrangement, recreational activities within the living arrangement, maintenance, security service, and similar services.

(B) Furnish supervision to each resident. "Supervision" means ensuring the resident's health, safety, and welfare by observing the resident while he or she engages in activities of daily living or other activities; reminding the resident to engage in or complete an activity of personal hygiene or other self-care activity; or, assisting the resident in making or keeping an appointment.

(C) Furnish personal care services to each resident. "Personal care services" mean services that include assisting a resident with activities of daily living, assisting a resident with self-administration of

medications in accordance with rule 5122-33-17 of the Administrative Code, and preparing special diets, if the living arrangement furnishes special diets in accordance with rule 5122-33-20 of the Administrative Code.

(D) Accept the allowable fee in rule 5122-36-05 of the Administrative Code as payment in full for all accommodations, supervision, and personal care services the living arrangement provides to the RSS resident. The living arrangement shall not request additional payment for these services from the resident, the resident's family, or any other local, state, or federal agency.

(E) Provide ODMH's designee with access to any RSS resident's records, including a resident's financial records, and any mental health plans of care as defined in rule 5122-33-18 of the Administrative Code.

(F) Allow each resident to meet privately with ODMH's designee.

(G) Notify ODMH's designee before transferring or discharging a resident to another living arrangement.

(H) Notify ODMH's designee of any significant changes in the resident's status that might affect the resident's needs.

(I) Not act as legal guardian or power of attorney for any resident unless appointed guardian or named power of attorney before July 1, 2000. However, the living arrangement may act as a resident's authorized representative.

(J) Maintain the appropriate licensure or certification.

(K) Return any RSS payment that it receives for a resident who was disenrolled from the program or left the living arrangement before the beginning of the month for which the payment was made.

(L) Give a prorated portion of any RSS payment to a resident who finds it necessary to leave the living arrangement due to extenuating circumstances before the end of the month for which the payment was made. The living arrangement shall pay even if the resident fails to give the minimum notice of departure that an admissions agreement or other contract between the living arrangement and the resident requires. Examples of extenuating circumstances include:

(1) The living arrangement cannot provide the level of care that the resident's mental, emotional, or physical condition requires;

(2) The health, safety, or welfare of the resident or any other person residing in the living arrangement requires a transfer or discharge;

(3) The living arrangement no longer has a current, valid license or certification; or,

(4) The living arrangement goes out of business.

(M) Permit each resident to have daily access to his or her personal funds during regularly-scheduled office hours, as specified in a posted notice that is available to each resident.

(N) Have each resident sign receipts for all funds exchanged between the resident and the living arrangement including payment for care, spending money, and any purchases the living arrangement makes on the resident's behalf. Additionally, the living arrangement shall provide each resident with a quarterly itemized account statement, and, if the resident gives permission to do so, the living arrangement shall provide ODMH's designee with this statement.

(O) Provide transportation for each resident as needed. If the living arrangement provides transportation for a charge to the resident, the living arrangement shall provide the resident with complete information regarding the living arrangement's transportation policy, including information concerning costs, and other transportation options available to the resident.

(P) Refrain from charging a resident more than the usual and customary rate for furnishing transportation or purchasing items.

(Q) Provide for the resident's needs, as determined by ODMH's designee. If the living arrangement cannot meet the resident's needs, it shall cooperate with ODMH's designee to relocate the resident to a living arrangement that can meet the resident's needs.

Effective: 02/17/2012

R.C. 119.032 review dates: 11/30/2011 and 02/17/2017

Promulgated Under: 119.03

Statutory Authority: 5119.69, Section 1616(B)(2) of the Social Security Act

Rule Amplifies: 5119.69

Prior Effective Dates: 7-1-200, 9-29-2002, 3-7-2011

5122-36-05 Allowable fee.

(A) The allowable fee for a particular living arrangement is the amount a resident pays to a living arrangement. The allowable fees are listed in "Table 1" to this rule.

Table 1

LIVING ARRANGEMENT	ALLOWABLE FEE
Adult family home	\$774
Adult foster home	\$774
Adult group home	\$877
Community mental health housing	\$618
Residential care facility	\$877
Residential facility	\$774

(B) The CDJFS uses the allowable fee to calculate the amount of supplement a resident receives based upon the resident's living arrangement as specified in Chapter 5101:1-17 of the Administrative Code.

Effective: 04/15/2012

R.C. 119.032 review dates: 11/30/2011 and 04/15/2017

Promulgated Under: 119.03

Statutory Authority: 5119.69, Section 337.30.50 of H.B. No. 153 (129th G.A)

Rule Amplifies: 5119.69, Section 337.30.50 of H.B. No. 153 (129th G.A)

Prior Effective Dates: 7-15-1982 (Temp), 12-1-1982, 7-1-1983 (Temp), 9-24-1983, 9-1-1984, 1-1-1985 (Emer.), 4-1-1985, 1-1-1986 (Emer.), 4-1-1986, 1-1-1987 (Emer.), 3-20-1987, 7-1-1988 (Emer.), 9-1-1988, 1-1-1989 (Emer.), 12-2-1991, 1-1-1992, 3-20-1992, 1-30-1993 (Emer.), 5-1-1993, 11-1-1993 (Emer.), 1-30-1994, 7-1-1994, 10-1-1995, 10-2-1995 (Emer.), 12-30-1995, 1-2-1998, 7-1-2000, 9-29-2002, 1-1-2008, 3-7-2011, 2/17/12

Chapter 5101:1-17 Residential State Supplement Program**5101:1-17-01 The residential state supplement (RSS) program.**

(A) The purpose of RSS is to provide cash assistance to medicaid-eligible aged, blind, or disabled adults who have increased needs due to a medical condition which is not severe enough to require institutionalization. The RSS cash payment is used together with the individual's personal income to help prevent premature or unnecessary institutionalization, and to deinstitutionalize those aged, blind, or disabled adults who have been inappropriately placed in long term care facilities and who can return to the community through alternative living arrangements.

(B) Definitions.

(1) "Individual," for the purpose of this rule, means a person who is applying for or receiving RSS benefits.

(2) "RSS administrative agency" means the Ohio department of mental health or its designee.

(C) RSS registration and enrollment process.

(1) The RSS application process is initiated upon receipt of:

(a) A completed JFS 07120 "Residential State Supplement Referral" (rev.3/2003) from the residential state supplement administrative agency verifying that the individual has been selected for placement in the RSS program; and

(b) A medicaid application, if the individual is not currently in receipt of medicaid.

(2) If the individual completes the JFS 07120 at the CDJFS, a copy of the JFS 07120 will be forwarded to the residential state supplement administrative agency to register the individual for the RSS program.

(3) If the individual submits the JFS 07120 to the CDJFS by mail, a copy of the JFS 07120 will be forwarded to the residential state supplement administrative agency to register the individual for the RSS program.

(4) The signature date on the JFS 07120 shall be the RSS application date. In some instances, medicaid retroactive eligibility must be determined in accordance with Chapter 5101:1-38 of the Administrative Code to cover the RSS protected date.

(D) County department of job and family services responsibilities.

(1) The determination of eligibility for RSS shall be coordinated between the CDJFS and the residential state supplement administrative agency.

(a) The CDJFS is responsible for determining eligibility for medicaid and financial eligibility for RSS.

(b) The residential state supplement administrative agency is responsible for determining eligibility for RSS placement, appropriate level of care and the subsequent monitoring of the placement to insure that the individual's needs continue to be met.

(c) The CDJFS shall inform the residential state supplement administrative agency of the individual's eligibility for medicaid and an RSS payment, the type of RSS living arrangement that can be

supplemented, and the amount of the RSS payment that can be authorized. Since the RSS financial need standards vary according to the RSS living arrangement, an individual or couple may be eligible for an RSS payment for one type of RSS living arrangement but not another.

(d) The CDJFS shall also inform the residential state supplement administrative agency of any change in the individual's or couple's medicaid and/or RSS financial eligibility.

(2) Once the individual has been selected for enrollment, the CDJFS in the county in which the individual resides shall accept and process the JFS 07120 that has been submitted by the residential state supplement administrative agency in accordance with the application procedures outlined in Chapter 5101:1-38 of the Administrative Code. A copy of the JFS 07120 shall be maintained in the assistance group's case record that is located in the CDJFS.

(3) For an individual who is not already receiving medicaid, the CDJFS shall preview medicaid eligibility and RSS financial eligibility within five working days of receipt of the JFS 07120 and medicaid application from the residential state supplement administrative agency.

(4) For an individual who is receiving medicaid, the CDJFS shall, within five working days of receipt of the JFS 07120, determine if the individual meets the RSS financial eligibility criteria. The CDJFS must notify the residential state supplement administrative agency of the results of the preview of RSS and medicaid eligibility.

(5) The CDJFS shall not delay the determination of eligibility for other assistance programs when RSS eligibility is still pending.

(6) The CDJFS shall not treat the level of care determination for RSS eligibility as evidence that the limiting physical factor requirement for medicaid eligibility as defined in rule 5101:1-39-03 of the Administrative Code has been met.

(7) If RSS income or resource eligibility are not met, the CDJFS shall deny the RSS application. The denial notice shall be sent to the applicant and authorized representative, if any. A copy of the denial notice shall also be issued to the residential state supplement administrative agency.

(8) The CDJFS shall document in the case record that the individual has received an appropriate level of care determination, and shall identify the RSS placement.

(E) Individual responsibilities.

(1) The individual shall cooperate with the CDJFS in order to determine eligibility for RSS.

(2) The individual is responsible for reporting changes within ten days to the CDJFS.

Replaces: 5101:1-17-01, 5101:1-17-03, 5101:1-17-04

Effective: 09/29/2011

R.C. 119.032 review dates: 09/01/2016

Promulgated Under: 111.15

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Rule Amplifies: 5111.01, 5111.011, 5119.69

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5101:1-17-02 RSS eligibility requirements.

(A) Non-financial eligibility requirements. The individual must complete a JFS 07120 "Residential State Supplement Referral" (rev. 3/2003) and meet all of the following criteria to be enrolled into the RSS program:

- (1) A county department of job and family services (CDJFS) must have determined the individual to be eligible for medicaid.
- (2) The individual must currently reside in a skilled nursing facility or need at least a protective level of care as defined in rule 5101:3-3-08 of the Administrative Code.
- (3) The individual must not require more than one hundred twenty days of skilled nursing care, as defined in section 3721.01 of the Revised Code, during any twelve month period unless the individual resides in a licensed residential care facility authorized to provide skilled nursing care in accordance with section 3721.011 of the Revised Code.
- (4) The individual must not have a cognitive impairment which requires the presence of another person on a twenty-four hour a day basis for the purpose of supervision to prevent harm.
- (5) The individual must be accepted for placement or residing in an approved community living arrangement, and a residential state supplement administrative agency must have determined that the facility is appropriate for the individual's needs in accordance with section 5119.69 of the Revised Code. The appropriate living arrangements are:
 - (a) An "adult foster home" certified under section 5119.692 of the Revised Code;
 - (b) An "adult family home" as defined in section 5119.70 of the Revised Code, that is licensed as an adult care facility under section 5119.73 of the Revised Code;
 - (c) An "adult group home" as defined in section 5119.70 of the Revised Code, that is licensed as an adult care facility under section 5119.73 of the Revised Code;
 - (d) A "residential care facility" as defined in section 3721.01 of the Revised Code, that is licensed under section 3721.02 of the Revised Code;
 - (e) A residential facility of the type defined in section 5119.22 of the Revised Code, that is licensed by the Ohio department of mental health; or
 - (f) An apartment or room that is used to provide community mental health services, is certified by the Ohio department of mental health under section 5119.611 of the Revised Code, and is approved by a board of alcohol, drug addiction, and mental health services in accordance with section 340.03 of the Revised Code.
- (6) The individual must not be related to the owner or caregiver of the RSS living arrangement.
- (7) The individual must not be a participant in any federal 1915C waiver program.
- (8) The individual must not be a participant in ODJFS' program of all-inclusive care for the elderly (PACE).
- (9) The individual must not be enrolled in a medicare or medicaid-certified hospice program.

(10) The residential state supplement administrative agency must have funds available to make another RSS placement.

(11) The individual must agree to participate in the development of a plan of care that includes residential needs and supports, and must sign the RSS resident agreement.

(12) The individual must execute a release of information form permitting exchange of information between the RSS provider and other care providers and key contacts as needed for continuity of care and eligibility determination.

(13) An individual who has been selected by the residential state supplement administrative agency for an RSS enrollment eligibility determination, or the individual's authorized representative, must apply for medicaid if he or she is not currently a medicaid recipient. The application for medicaid must be filed with the CDJFS within thirty days of the day the individual is notified of the selection.

(B) Financial eligibility requirements.

(1) The definitions of earned and unearned income in Chapter 5101:1-37 of the Administrative Code are applicable to the RSS program.

(2) When a husband and wife reside in the same RSS facility and both have appropriate levels of care, the CDJFS shall determine their RSS financial and resource eligibility collectively utilizing the appropriate couple need standards.

(3) When a husband and wife reside in the same RSS facility and only one of them has an appropriate level of care, the CDJFS shall determine RSS financial and resource eligibility utilizing the appropriate individual need standard. The spouse who does not have the necessary level of care shall have medicaid eligibility determined in accordance with Chapter 5101:1-39 of the Administrative Code as an individual with one exception: income cannot be deemed to or from the RSS-eligible spouse.

(4) The financial eligibility methodologies for medicaid and RSS are the same, with three exceptions:

(a) SSI income is countable income in the RSS program, except that all SSI cost-of-living adjustments after October 1, 1982, are disregarded for all RSS assistance groups with SSI income.

(b) The medicaid spenddown provision does not apply in the RSS program. If an individual has countable income equal to or in excess of the financial need standard for the appropriate RSS living arrangement, the individual is ineligible for RSS.

(c) The RSS program has no deeming provision. For an RSS spouse and a non-RSS spouse residing in the same living arrangement, there is no deeming to or from the RSS spouse. They are both treated as individuals for purposes of determining RSS eligibility. If applicable, the non-RSS spouse shall have medicaid eligibility determined as an individual in accordance with Chapter 5101:1-39 of the Administrative Code with no deemed income allocation from the RSS spouse.

(5) Twenty dollars of any income, earned or unearned other than income from SSI, is disregarded. Only one twenty dollar disregard is applied per couple if both husband and wife are eligible for RSS.

(6) The disregard allowed from an eligible individual's earned income is sixty-five dollars plus one-half of the remaining income.

(7) Earnings which are used to pay for blind work expenses and/or impairment-related work expenses may be deducted from the earned income in accordance with Chapter 5101:1-39 of the Administrative Code.

(8) If the RSS individual's countable income is less than the financial need standard for the appropriate RSS living arrangement, but the individual's RSS enrollment is not yet completed, the CDJFS shall pend the RSS application until the RSS enrollment determination is completed.

(9) If the RSS individual's countable income is less than the financial need standard for the appropriate RSS living arrangement, the individual is eligible for an RSS payment.

(10) The CDJFS shall determine retroactive medicaid eligibility in accordance with Chapter 5101:1-38 of the Administrative Code for coverage of non-RSS medicaid services.

(11) Qualified medicare beneficiary (QMB) and specified low-income medicare beneficiary (SLMB) eligibility determinations.

(a) QMB and SLMB eligibility determinations shall be made upon application for all programs, including RSS. If eligible, the CDJFS shall approve QMB or SLMB unless the individual, after having been fully informed of the benefits of each covered group, chooses not to have QMB or SLMB approved.

(b) If QMB or SLMB eligibility does not exist, the CDJFS shall deny QMB or SLMB. If RSS eligibility is subsequently approved, the CDJFS shall enroll the individual in the state buy-in only.

(c) QMB and SLMB financial eligibility is determined for the husband and wife as a couple even if only one has an appropriate level of care.

Replaces: 5101:1-17-02, 5101:1-17-04

Effective: 09/29/2011

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5101:1-17-03 Determination of RSS payment.

(A) The residential state supplement (RSS) payment to the assistance group shall be equal to the difference between the countable income and the financial need standard for the appropriate RSS living arrangement.

(B) The approval date for the RSS payment cannot precede the signature date on the JFS 07120 "Residential State Supplement Referral" (rev. 3/2003), the date of placement in an appropriate RSS living arrangement, or the date when all financial and resource eligibility requirements are met, whichever occurs last.

(C) When an individual leaves an RSS placement after the monthly RSS payment has been made, a refund of the payment will not be made to the individual. If an individual leaves an RSS placement and

moves to another RSS living arrangement and the monthly RSS payment has been made to the previous residence, a second monthly RSS payment will not be made for the new residence.

(D) When an individual leaves an RSS placement the CDJFS must determine the individual's continued medicaid eligibility. If an adverse action is required (e.g., a change to delayed spenddown medicaid) the individual must be afforded hearing rights in accordance with Chapter 5101:6-2 of the Administrative Code.

(E) When an individual moves from a nursing facility or a personal residence into an RSS living arrangement the first day of the month and is otherwise eligible for RSS, the individual is eligible for a full month's RSS payment.

(F) When an individual moves into an RSS living arrangement on a date other than the first of the month and is otherwise eligible for RSS, the first month's payment is calculated according to the following formula:

(1) Determine the regular monthly RSS payment in accordance with paragraph (A) of this rule.

(2) Divide the monthly RSS payment amount by the number of days in the month to arrive at the daily supplement amount. Round amounts up to the nearest dollar.

(3) Multiply the daily supplement amount by the actual number of days of RSS placement in the month. The actual number of days of RSS placement in the month includes the day that the individual moves into the RSS living arrangement through the last day of the month.

(4) The resulting product is the prorated RSS payment.

(G) Impact of temporary institutional placement.

(1) Individuals who temporarily enter a public or medicaid certified facility are potentially eligible to receive full uninterrupted RSS benefits during the first three full months of institutional placement. These RSS benefits are intended to allow the individual to maintain and pay for the expense of the RSS living arrangement in which the individual intends to live when discharged.

(2) Individuals are eligible for continued RSS benefits provided the following criteria are met:

(a) Institutional placement. The individual must continuously reside in one or more of the following: a public medical institution, a public psychiatric institution, a medicaid approved hospital, or a Title XIX certified long term care facility (LTCF).

(b) Recipient status. The individual must be eligible for an RSS payment both the month prior to and the month of institutional placement.

(c) Physician's certification. The individual's physician must provide a statement that the individual's period of institutional placement is not likely to exceed ninety consecutive days, beginning the day after the day of admission.

(d) Need to maintain the RSS facility placement. The individual must demonstrate the need to continue to maintain the placement in the RSS facility during the institutional placement, and that the RSS facility will reserve the individual's space. A written statement from the RSS facility to this effect is necessary.

(e) Evidence documenting that the criteria listed in paragraphs (G)(2)(a) to (G)(2)(d) of this rule have been met must be provided by the earlier of:

- (i) Ninety days after the date of admission to the institution; or
 - (ii) The day of release from the institution.
- (f) Individuals in receipt of supplemental security income (SSI) must provide verification that the social security administration (SSA) has approved continued SSI benefits.
- (3) The CDJFS shall continue RSS payments to all individuals meeting the criteria in paragraph (G)(2) of this rule.
- (4) RSS payments and personal income are exempt from consideration as income in the long term care patient liability calculation for individuals entering a LTCF.
- (a) This income exemption continues through the last day of the month in which the temporary period of institutional placement ends.
- (b) Effective the following month, if the RSS individual remains in an institutional placement, the CDJFS must stop the RSS payment and count the individual's income in the patient liability calculation.
- (5) Any RSS payments made under the continued benefit provision are not overpayments if the recipient's actual stay exceeds the expected stay of ninety days or less.
- (6) Prior notice is not required to stop RSS payments and start vendor payments to a long term care facility.
- (H) If the license or certification of the RSS living arrangement expires or is suspended or revoked, and a new alternative living arrangement is not secured for the individual, the RSS case is terminated.
- (1) Upon notification that the RSS living arrangement's license or certification has expired or has been suspended or revoked, the CDJFS must provide prior notice that the individual's RSS eligibility will be terminated because the individual no longer resides in an RSS living arrangement.
- (2) When the living arrangement's license or certification has been renewed, the RSS payment may be made retroactive to the effective date of the living arrangement's recertification, as long as all other RSS eligibility factors are met.

Replaces: 5101:1-17-05

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5101:1-17-04 [Rescinded] Medicaid and RSS financial eligibility determinations.

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Statutory Authority: 5111.01

Rule Amplifies: 5111.01, 5111.011, 173.35

Prior Effective Dates: 12/1/82, 7/1/83 (Emer.), 9/24/83, 9/1/84, 1/1/89 (Emer.), 3/6/89, 9/12/91 (Emer.), 12/2/91, 1/30/94, 10/1/02

5101:1-17-05 [Rescinded] Determination of RSS payment.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011

Promulgated Under: 111.15

Statutory Authority: 5111.01

Rule Amplifies: 5111.01, 5111.011, 173.35

Prior Effective Dates: 7/15/82 (Emer.), 12/1/82, 1/1/89 (Emer.), 3/6/89, 4/1/89, 9/12/91, 1/30/94, 10/1/02, 7/1/11 (Emer.)

5101:1-17-06 [Rescinded] RSS financial need standards and allowable fees.

Effective: 09/29/2011

R.C. 119.032 review dates: 07/14/2011

Promulgated Under: 111.15

Statutory Authority: 5111.01

Rule Amplifies: 5111.01, 5111.011, 173.35

Prior Effective Dates: 5/1/98, 10/1/02

5101:1-17-07 [Rescinded] Pass-along of SSI income cost-of-living adjustments (COLA) for RSS.

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Promulgated Under: 111.15

Statutory Authority: 5111.01

Rule Amplifies: 5111.01, 5111.011, 173.35

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Residential Care Facilities / Assisted Living

Overview

"Residential care facility" is a home that provides either of the following:

- (a) Accommodations for seventeen or more unrelated individuals, and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment;
- (b) Accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment, and, to at least one of those individuals supervision of special diets or application of dressings, or provide for the administration of medication to residents, to the extent authorized.

A residential care facility may admit or retain an individual requiring medication, including biologicals, only if the individual's personal physician has determined in writing that the individual is capable of self-administering the medication or the facility provides for the medication to be administered to the individual by a certified home health agency, a licensed hospice care program, or a member of the staff of the residential care facility who is qualified to perform medication administration. Medication may be administered in a residential care facility only by the following persons authorized by law to administer medication: a registered nurse (RN); a licensed practical nurse (LPN) who holds proof of successful completion of a course in medication administration approved by the board of nursing and who administers the medication only at the direction of a registered nurse or a physician authorized to practice medicine and surgery or osteopathic medicine and surgery.

In assisting a resident with self-administration of medication, any member of the staff of a residential care facility may remind a resident when to take medication and watch to ensure that the resident follows the directions on the container; assist a resident by taking the medication from the locked area where it is stored and handing it to the resident. If the resident is physically unable to open the container, a staff member may open the container for the resident. If a resident is physically unable to place a dose of medicine to the resident's mouth without spilling it, a staff member may place the dose in a container and place the container to the mouth of the resident.

A residential care facility may admit or retain individuals who require skilled nursing care beyond the supervision of special diets, application of dressings, or administration of medication, only if the care will be provided on a part-time, intermittent basis for not more than a total of one hundred twenty days in any twelve-month period. Skilled nursing care may be provided by a certified home health agency, licensed hospice care program, or a member of the staff of a residential care facility who is qualified to perform skilled nursing care.

The Ohio Department of Health's (ODH) Bureau of Long Term Care Quality is responsible for enforcement of the Ohio Revised Code and Ohio Administrative Code laws and rules in about 533 licensed residential care facilities in Ohio. Each of the residential care facilities in Ohio receives at least one unannounced survey (inspection) during a 9 to 15 month survey cycle. During these surveys, all aspects of care and services are evaluated based on state laws and rules. Each residential care facility is required to display a copy of the most recent survey. This allows anyone visiting or residing in the facility to see if the facility received deficiencies on the survey. Other ways that a family or interested party can evaluate a provider is to visit the facility at different times of the day to observe staff interacting with residents. Seeing the types of activities being provided, being present at meal times and talking with staff also offer excellent opportunities to evaluate a residential care facility.

ODH staff responsible for completing the surveys in nursing homes are highly trained professionals. Survey teams are comprised of registered nurses, registered dietitians, registered sanitarians, and licensed social workers. Team size and composition are based on the size of the facility, past history of compliance with rules, and identified areas of special need.

Investigation of a complaint in a residential care facility is completed by surveyors after receiving the written documentation from the Ohio Department of Health complaint unit located in Columbus, Ohio. The toll free number for registering complaints is 1-800-342-0553. The complainant may choose to be anonymous.

Mailing Address:

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Residential Care Facilities/Assisted Living
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Last Updated: 10/6/11

5101:3-3-06 Criteria for the protective level of care.

(A) This rule describes the criteria for an individual to meet the protective level of care.

(B) The criteria for the protective level of care is met when:

(1) The individual's needs for long-term services and supports (LTSS), as defined in rule 5101:3-3-05 of the Administrative Code, are less than the criteria for the intermediate or skilled levels of care, as described in paragraphs (B)(4), (C), and (D)(4) of rule 5101:3-3-08 of the Administrative Code.

(2) The individual's LTSS needs are less than the criteria for the ICF-MR-based level of care, as defined in rule 5101:3-3-05 of the Administrative Code.

(3) The individual has a need for:

(a) Less than twenty-four hour support, as defined in rule 5101:3-3-05 of the Administrative Code, in order to prevent harm due to a cognitive impairment, as diagnosed by a physician or other licensed health professional acting within his or her applicable scope of practice, as defined by law; or

(b) Supervision, as defined in rule 5101:3-3-05 of the Administrative Code, of one activity of daily living (ADL), as defined in rule 5101:3-3-05 of the Administrative Code and as described in paragraph (C) of this rule, or supervision of medication administration, as defined in rule 5101:3-3-05 of the Administrative Code; and

(c) Assistance, as defined in rule 5101:3-3-05 of the Administrative Code, with three instrumental activities of daily living (IADL), as defined in rule 5101:3-3-05 of the Administrative Code and as described in paragraph (D) of this rule.

(C) For the purposes of meeting the criteria described in paragraph (B)(3) of this rule, an individual has a need in an ADL when:

(1) The individual requires supervision of mobility in at least one of the following three components:

(a) Bed mobility;

(b) Locomotion; or

(c) Transfer.

(2) The individual requires supervision of bathing.

(3) The individual requires supervision of grooming in all of the following three components:

(a) Oral hygiene;

(b) Hair care; and

(c) Nail care.

(4) The individual requires supervision of toileting in at least one of the following four components:

(a) Using a commode, bedpan, or urinal;

(b) Changing incontinence supplies or feminine hygiene products;

(c) Cleansing self; or

(d) Managing an ostomy or catheter.

(5) The individual requires supervision of dressing in at least one of the following two components:

(a) Putting on and taking off an item of clothing or prosthesis; or

(b) Fastening and unfastening an item of clothing or prosthesis.

(6) The individual requires supervision of eating.

(D) For the purposes of meeting the criteria described in paragraph (B)(3) of this rule, an individual has a need in an IADL when:

(1) The individual requires assistance with meal preparation.

(2) The individual requires assistance with environmental management in all of the following three components:

(a) Heavy chores;

(b) House cleaning; and

(c) Yard work and/or maintenance.

(3) The individual requires assistance with personal laundry.

(4) The individual requires assistance with community access in at least one of the following three components:

(a) Accessing transportation;

(b) Handling finances; or

(c) Telephoning.

(5) The individual requires assistance with shopping.

Replaces: Part of 5101:3-3-08

Effective: 03/19/2012

R.C. 119.032 review dates: 03/01/2017

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.204

Prior Effective Dates: 9/24/93 (Emer.), 12/24/93, 7/1/08

5122-33-16 Resident agreement; other information to be provided upon admission.

(A) An ACF shall enter into a written resident agreement with each prospective resident prior to beginning residency in the facility. The agreement shall be signed and dated by the manager or owner and the prospective resident or, if the prospective resident is physically unable to sign and consents, another individual designated by the prospective resident. The facility shall provide both the prospective resident and any other individual signing on his or her behalf with a copy of the agreement and shall explain the agreement to them.

(B) The agreement required by paragraph (A) of this rule shall include at least the following items:

(1) An explanation of monthly charges to the resident including security deposits, if any are required, and a statement whether the facility or the resident will pay for the initial and annual assessments required by rule 5122-33-18 of the Administrative Code;

(2) A statement that no charges, fines, or penalties will be assessed against the resident other than those stipulated in the agreement;

(3) An explanation of the facility's policy for refunding monthly charges in the event of the resident's absence, discharge, or transfer from the facility and the facility's policy for refunding security deposits; and

(4) A written explanation of the extent and types of services the facility will provide to the resident.

(C) In addition to executing and explaining the resident agreement under paragraph (A) of this rule, upon admission of a resident, the facility shall provide:

(1) A copy of the facility's residents' rights policy and procedures required by paragraphs (D) and (E) of rule 5122-33-23 of the Administrative Code;

(2) The facility's smoking policy required by paragraph (I)(9) of rule 5122-33-22 of the Administrative Code;

(3) A copy of procedures to be used for the referral of residents for mental health evaluation and services and the role of the facility regarding the resident's receipt of appropriate services from mental health providers; and

(4) Any other facility policies that residents must follow to include "house rules" as may be applicable.

Effective: 02/17/2012

R.C. [119.032](#) review dates: 11/30/2011 and 02/17/2017

Promulgated Under: [119.03](#)

Statutory Authority: 5119.79

Rule Amplifies: 5119.79, [5119.81](#)

Prior Effective Dates: 5-6-1991 (Emer.), 8-4-1991, 12-16-1993 (Emer.), 2-25-1994, 9-5-1997, 10-15-2000, 10-1-2010

5122-33-17 Personal care services; resident medications; home health care.

(A) For the purposes of this rule, personal care services or skilled nursing care shall be considered to be provided by a facility if they are provided by a person employed by or associated with the facility or by another person pursuant to an agreement to which neither the resident who receives the services nor his or her sponsor is a party.

(B) An ACF shall provide personal care services to residents who require those services and may provide personal care services to other residents upon request. If a resident requires certain personal care services that the facility does not offer, the facility either shall arrange for the services to be provided or shall transfer the resident to an appropriate setting in accordance with section 5119.83 of the Revised Code and rule 5122-33-24 of the Administrative Code. Personal care services include, but are not limited to, the following:

(1) Assistance with walking and moving, dressing, grooming, toileting, oral hygiene, hair care, dressing, eating, and nail care;

(2) Assistance with self-administration of medication, in accordance with section 5119.701 of the Revised Code and paragraph (C) of this rule; and

(3) Preparation of special diets, other than complex therapeutic diets, for residents who require them, pursuant to the instructions of a physician or a licensed dietitian and in accordance with paragraph (B) of rule 5122-33-20 of the Administrative Code.

(4) Nothing in this paragraph shall be construed to permit personal care services to be imposed upon a resident who is capable of performing the activity in question without assistance.

(C) All medication taken by residents of an ACF shall be self-administered, except that medication may be administered to a resident as part of the skilled nursing care provided in accordance with division (B) of section 5119.86 of the Revised Code and paragraph (D) of this rule. Members of the staff of an ACF shall not administer medication to residents. No person shall be admitted to or retained by an ACF unless the person is capable of administering the person's own medications, as determined in writing by a physician, except that a person may be admitted to or retained by such a facility if his medication is administered as part of the skilled nursing care provided in accordance with division (B) of section 5119.86 of the Revised Code and paragraph (D) of this rule. Staff members of an ACF may do any of the following once they have received training in providing the services as required by paragraph (K)(2) of rule 5122-33-13 of the Administrative Code:

(1) Remind a resident when to take medication, and watch to ensure that the resident follows the directions on the container;

(2) Assist a resident in self-administration of medication by taking the medication from the locked area where it is stored and handing it to the resident. The staff member shall check the name on the prescription label and verify that the resident's name on the prescription label corresponds to the resident requesting the medication before handing it to the resident. The staff member may read the label and directions on the medication container to the resident upon request. The staff member also may remind the resident and any other individual designated by the resident when prescribed medication needs to be refilled. Staff members shall not assist a resident with self-administration of a prescription medication that belongs to another resident. If the resident is physically unable to open the container, a staff member may open the container for the resident; and

(3) Assist a physically impaired but mentally alert resident such as a resident with arthritis, cerebral palsy, or

Parkinson's disease in removing oral or topical medication from containers and in consuming or applying the medication upon request by or with the consent of the resident. If the resident is physically unable to place a dose of medicine to his or her mouth without spilling it, a staff member may place the dose in a container and place the container to the mouth of the resident. As used in this paragraph, "topical medication" means a medication other than a debriding agent used in the treatment of a skin condition or minor abrasion, and eye, nose, or ear drops excluding irrigations.

(D) No facility shall provide, or admit or retain any resident in need of skilled nursing care unless all of the following are the case:

(1) The care will be provided on a part-time, intermittent basis for not more than a total of one hundred twenty days in any twelve-month period by an appropriately licensed employee or contract employee of one or more of the following:

(a) A home health agency certified under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.301 , as amended;

(b) A hospice care program licensed under Chapter 3712. of the Revised Code;

(c) A nursing home licensed under Chapter 3721. of the Revised Code and owned and operated by the same person and located on the same site as the ACF if the requirements of paragraph (E) of this rule are met;

(d) A mental health agency, or ADAMHS board.

(2) The staff of the home health agency, hospice care program, nursing home, mental health agency, or ADAMHS board does not train facility staff to provide the skilled nursing care; and

(3) The individual to whom the skilled nursing care is provided is suffering from a short-term illness. As used in this paragraph, "short-term illness" means either a medical condition for which recovery can be expected to occur with not more than thirty-five consecutive days of skilled nursing care or a medical condition requiring skilled nursing care provided on a periodic, scheduled basis.

(4) If a resident's condition requires more skilled nursing care than permitted under this paragraph, the facility shall transfer or discharge the resident in accordance with section 5119.83 of the Revised Code and rule 5122-33-24 of the Administrative Code.

(E) If the skilled nursing care is to be provided by the nursing staff of a nursing home, the following requirements shall be met:

(1) The ACF shall evaluate the individual receiving the skilled nursing care at least once every seven days to determine whether the individual should be transferred to a nursing home;

(2) The ACF meets at all times the staffing requirements of rule 5122-33-13 of the Administrative Code;

(3) The nursing home does not include the cost of providing skilled nursing care to the ACF residents in a cost report filed under section 5111.26 of the Revised Code;

(4) The nursing home meets at all times the nursing home licensure staffing ratios established by rule 3701-17-08 of the Administrative Code;

(5) The nursing home staff providing skilled nursing care to ACF residents are registered nurses or licensed practical nurses licensed under Chapter 4723. of the Revised Code and meet the personnel qualifications for nursing home staff established by rule 3701-17-07 of the Administrative Code;

(6) The skilled nursing care is provided in accordance with the rules established for nursing homes under

section 3721.04 of the Revised Code;

(7) The nursing home meets the skilled nursing care needs of the ACF residents; and

(8) Using the nursing home's nursing staff does not prevent the nursing home or ACF from meeting the needs of the nursing home and ACF residents in a quality and timely manner.

(F) A home health agency or hospice care program that provides skilled nursing care pursuant to paragraph (D) of this rule shall not be associated with the ACF unless the facility is part of a home for the aged as defined in section 5701.13 of the Revised Code or the ACF is owned and operated by the same person and located on the same site as a nursing home licensed under Chapter 3721. of the Revised Code that is associated with the home health agency or hospice care program. In addition, the following requirements shall be met:

(1) The ACF shall evaluate the individual receiving the skilled nursing care not less than once every seven days to determine whether the individual should be transferred to a nursing home;

(2) If the costs of providing the skilled nursing care are included in a cost report filed pursuant to section 5111.26 of the Revised Code by the nursing home that is part of the same home for the aged, the home health agency or hospice care program shall not seek reimbursement for the care under the medical assistance program established under Chapter 5111. of the Revised Code.

(G) In addition to the requirements of paragraph (C) of this rule, ACFs shall handle residents' medications in accordance with this paragraph.

(1) The facility shall ensure that residents' prescription medications are kept in locked storage areas, except that medications requiring refrigeration shall be refrigerated. All prescribed medications shall be clearly labeled with the resident's name, the name and strength of the medication and the prescription number, if any, the date dispensed, the name of the physician, and the instructions for use.

(2) The facility shall not remove and repackage medication from the pharmacy-dispensed container.

(3) The facility shall send a resident's medications with the resident upon permanent transfer or discharge, or dispose of the medications with the consent of the resident and in accordance with applicable state and federal laws, regulations, and rules.

(4) The facility shall not recommend over-the-counter medications to residents.

(5) The facility shall keep a written list of all medications prescribed for each resident and shall make a good-faith effort to keep the list current.

(H) An ACF may assist a physically impaired, but mentally alert resident, by taking out and arranging equipment or supplies used for routine, self-monitoring tests relating to chronic conditions and assisting the resident in maintaining a record of test results, upon request of the resident. Nothing in this paragraph shall be construed to permit an ACF staff member, manager or operator to interpret routine, self-monitoring test results, or to provide treatment, or to modify currently prescribed treatment as the result of self-monitoring tests. An ACF staff member, manager or operator may encourage a resident to contact a licensed health care professional to report self-monitoring test results.

(I) In the case of an ACF providing personal care services to one or more individuals with mental illness who are referred by or are receiving mental health services from a mental health agency, the facility shall commence providing personal care services to those residents in accordance with the mental health plan for care upon agreement to the plan by all necessary parties.

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R.C. 119.032 review dates: 11/30/2011 and 02/17/2017

Promulgated Under: 119.03

Statutory Authority: 5119.79, 5119.88

Rule Amplifies: 5119.70, 5119.701, 5119.79, 5119.86, 5119.88

Prior Effective Dates: 5-6-1991 (Emer.), 8-4-1991, 12-16-1993 (Emer.), 2-25-1994, 10-15-2000, 6-17-2001, 6-1-2006, 10-1-2010

5122-35-09 Responsibilities of operators.

The operator of a certified adult foster home shall comply with all of the following:

(A) The operator shall provide accommodations, personal care services, and supervision, as needed by residents;

(B) The operator shall provide snacks and three nutritious, well-balanced meals, in accordance with the resident's dietary needs;

(C) Upon request by the AAA, the operator shall provide a written description of the previous week's meals to the AAA;

(D) The operator shall provide a laundry service, as needed, for the bed linens, towels, and clothing of the resident;

(E) In the event of acute illness, accident, nursing facility admission, or hospitalization of a resident, the operator shall contact the resident's physician and/or source of medical care immediately. The operator shall also notify any emergency contact pre-designated by the resident, and the resident's RSS case manager, if applicable, as soon as possible, but not later than twenty-four hours after the emergency occurs. The operator shall document the occurrence and contacts in the resident's record;

(F) The operator shall maintain on the premises, for each resident, a medical statement certifying that the resident is free from communicable disease, as defined by rule [3701-3-02](#) of the Administrative Code, that is signed and dated by a licensed physician, and is updated annually;

(G) The adult foster home operator shall enter into a resident agreement with each prospective resident that is signed and dated by the operator and the resident (or the resident's legal representative) prior to the date on which the resident moves into the home. The operator shall maintain the resident agreement on the premises of the home. The agreement shall include at least the following:

(1) An explanation of monthly charges for which the resident is financially responsible;

(2) A statement that no charges, fines, or penalties other than those stipulated in the agreement will be assessed against the resident;

(3) An explanation of the operator's policies for refunding monthly charges in the event of the resident's absence, discharge, or transfer from the home;

(4) An explanation of the extent and types of services the operator will provide to the resident;

(5) An explanation of residents' rights; and,

(6) A clause that outlines how the agreement may be terminated by either party.

(H) The operator shall not provide, admit, or retain any resident in need of skilled nursing care, unless all of the following apply:

(1) The care is provided on a part-time, intermittent basis for not more than a total of one hundred twenty days in any twelve-month period by a home health agency certified under Title XVIII of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C.301, as amended, or a hospice care program licensed under Chapter 3712. of the Revised Code;

(2) The home health agency does not train the caregiver to provide the skilled nursing care; and,

(3) The individual to whom the skilled nursing care is provided is suffering from a short-term illness.

(I) The operator shall discharge the resident if the resident's condition requires more skilled nursing care than permitted under paragraph (H) of this rule;

(J) An operator may not admit or retain any resident who is not capable of taking care of the resident's own medication and biologicals, as determined and documented by the resident's personal physician, unless the medication is administered by a home health agency or hospice home care program. The operator shall keep all medication in a locked area. The caregiver may do any of the following after the caregiver has received training:

(1) Remind a resident when to take medication and watch to ensure that the resident follows the directions on the container:

(2) Assist a resident in self-administration of medication by taking the medication from the locked area where it is stored and handing it to the resident. Prior to handing the medication to the resident, the caregiver shall check the name on the prescription label and verify that it is the name of the resident requesting the medication. The caregiver may read the label and directions to the resident upon request. The caregiver may remind the resident when the prescribed medication needs to be refilled. Caregivers shall not assist a resident with a prescription that belongs to another resident. If the resident is physically unable to open the container, a caregiver may open the container for the resident; and,

(3) Assist a physically impaired, but mentally alert resident in removing oral or topical medication from containers and in consuming or applying the medication upon request by or with the consent of the resident. If the resident is physically unable to place a dose of medicine in the resident's mouth without spilling it, a caregiver may place the dose in a container and place the container in the mouth of the resident.

(K) If the adult foster home operator agrees to manage a resident's funds, the operator shall do the following:

(1) Deposit any amount over two hundred dollars in an interest-bearing account separate from the home's operating accounts;

(2) Deposit any amount less than two hundred dollars in either a petty cash fund or an interest bearing account;

(3) Ensure that all interest earned on funds belonging to a resident is credited to the resident;

(4) Provide the resident with access to the resident's money at all times and encourage the resident to manage the resident's own money independently; and,

(5) Limit any purchases on behalf of the resident by the operator or a caregiver using a resident's funds to only those purchases that are requested by the resident and for which a receipt can be produced.

(L) Upon the request of the resident, the operator shall provide a written statement regarding the status of the resident's property. The operator shall provide the resident with a final accounting and return all of the resident's property to the resident at time of permanent transfer or discharge. Upon the death of the resident, the operator shall release all of the resident's property to the individual administering the resident's estate;

(M) No operator, caregiver, or staff person of an adult foster home, or the family member of an operator, caregiver, or staff person, may serve as the legal guardian of a resident, unless the individual was appointed guardian prior to July 13, 2003;

(N) The operator shall notify the AAA of any incidents or issues of the physical facility that may have an impact on provider certification;

(O) The operator shall reside in the home and shall be present in the home a sufficient amount of time to meet the needs of residents;

(P) The operator shall notify each resident's PAA case manager and sponsor of the caregiver's planned absences from the home. The operator shall also document this in the resident's records. An alternative caregiver shall be designated to carry out the duties of the primary caregiver when the caregiver is on vacation or absent for more than six continuous hours; and,

(Q) The operator shall submit to the AAA for review, contingency plans covering the unexpected absence, vacation, or disability of the caregiver. The AAA shall review the contingency plans and shall disapprove the plans if determined to be insufficient to protect the residents in the home and shall require the applicant to submit new plans. These plans shall be approved by the AAA before the home is certified or recertified.

Replaces: 173-36-03

Effective: 01/01/2008

R.C. 119.032 review dates: 01/31/2012

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Statutory Authority: 173.02, 173.36

Rule Amplifies: 173.36

Prior Effective Dates: Eff. 2/1/94 (Emer.); 5/3/94; 4/26/98; 7/13/03