Department of Mental Health & Addiction Services

Residential State Supplement (RSS) Program Application

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

- ☐ RSS Program Application
- ☐ RSS Authorization for Release of Information
- ☐ ODJFS 07120 Form
- ☐ Proof of Legal Guardianship (if applicable)

*** Only completed applications submitted correctly will be reviewed. All forms & instructions are available online at www.mha.ohio.gov/RSS**

Demographic Information

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

Eligibility Criteria Checklist

Check the appropriate boxes below.

- Is the applicant age 18 or older? ☐ Yes ☐ No
- Is the applicant enrolled in Medicaid (not a waiver program)? ☐ Yes ☐ No
- Is the applicant Currently receiving Social Security, SSI, or SSDI? ☐ Yes ☐ No
- May the applicant meet a Protective Level of Care? ☐ Yes ☐ No

RSS Eligible Living Arrangement

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

Name of Residence:	**Address:**
County:	**Move in Date:**
Contact Name:	**Phone/Email:**

**Please refer to the list of eligible living arrangements at www.mha.ohio.gov/RSS*

Representative Payee Information

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

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

Name of Representative Payee/Agency:	**Address:**	**Email/Phone/Fax**