Department of Behavioral Health

Residential State Supplement (RSS) Program Application

Use the checklist to make sure your application is complete. All forms & instructions are available at dbh.ohio.gov/RSS.

- ☐ RSS Program Application (Pages 1 – 2)
- ☐ RSS Authorization for Release of Information
- ☐ ODM 07120 Form
- ☐ Proof of Legal Guardianship (if applicable)

Complete RSS applications may be submitted via encrypted email to RSS@dbh.ohio.gov or fax to (614) 485-9747.

Demographic Information

Individual's Name (Last, First):	**Date Submitted:**	
Social Security Number (required):	**Date of Birth:**	**Gender:** ☐ Female ☐ Male
Referral Source Name & Organization Name:	**County of Referral:**	
Relationship to Applicant:	**Referral Source Email/Phone (required):**	
Diagnosis Information, please check all that apply: ☐ Mental Illness or Substance Use Disorder ☐ Intellectual or Developmental Disability ☐ Other Disability	**Legal Guardian Name & Email/Phone (if applicable):**	
Applicant's Current Residence/Address:	**Is the applicant currently**: Receiving treatment in a nursing facility? ☐ Yes ☐ No Living in a Class 2 Residential Facility (RF2)? ☐ Yes ☐ No Applying for Recovery Requires a Community? ☐ 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

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Eligible Living Arrangement

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

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

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

Level of Care Assessment

Please list contact information below so OhioMHAS can request a level of care (LOC) assessment. This is who your Area Aging on Agency will contact to schedule the assessment.

Contact Name & Organization:	**Relationship to applicant:** ☐ Case Manager ☐ Facility Operator ☐ Other _____
Direct line and extension/Cell (required):	**Email:**

If an individual is residing in a nursing home **when the RSS application is submitted to DBH, leave this section blank.*

Representative Payee Information

Will the individual have a Representative Payee for RSS benefits?

☐ Yes ☐ No (This means the RSS enrollee will directly receive all benefits, then pay rent to the facility.)

If yes, please list below. *Do not list the nursing facility or home operator.*

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