OHIO DEPARTMENT OF MEDICAID

Residential State Supplement (RSS) Referral for Enrollment

This is a referral for enrollment in the Residential State Supplement (RSS) program. The individual must have a completed Medicaid application and meet certain non-financial, financial, and resource requirements to be eligible for RSS.

SECTION A *(to be completed by the RSS Applicant or Legal Guardian)*

I, the undersigned, hereby authorize the Ohio Department of Mental Health and Addiction Services *(OhioMHAS)* as the RSS administrative agency, the Ohio Department of Medicaid (ODM), and the County Department of Job and Family Services (CDJFS) to exchange such information as necessary regarding my eligibility for RSS Cash and Medicaid assistance.

Name of Individual or Legal Guardian *(if applicable*)	Signature of Individual or Legal Guardian *(if applicable)*	Date

SECTION B *to be completed by OhioMHAS and processed by the local CDJFS*

Referral Information				
Date of Referral to CDJFS	Applicant's Name *(Last, First)*	Social Security Number	Medicaid Case Number	
RSS Effective Date	Living Arrangement Type ☐ Class Two Residential Facility *(RF2; licensed by MHAS)* ☐ Residential Care Facility (RCF/Assisted Living; licensed by ODH)			
Facility Name	Facility Address			
	Street Address	City	State	Zip

Facility Phone	Facility County	County Transfer *(if applicable)*

Protective Payee Information *(if applicable; NOT Authorized Representative)*			
Protective Payee Name	Payee Phone Number		
Payee Mailing Address			
Street Address	City	State	Zip

Distribution: *Original to OhioMHAS, copy to CDJFS*