

Optional State Supplemental Payment Application Instructions

The Optional State Supplemental Payment Program (OSSP) is a special supplement that is paid to eligible individuals who reside in an Adult Foster Care Home. The Adult Foster Care Home consists of a Certified Residential Facility (CRF) or Adult Living Facility (ALF). Individuals must be eligible to receive Social Security Income (SSI) payments or meet the SSI eligibility standards. To apply for OSSP, an application must be completed and submitted to the Department of Health Care Finance DC Optional State Supplemental Program.

The purpose of this form is to provide instructions to Adult Foster Care Home Operators on how to complete and submit the OSSP Application for an applicant's certification (move-in), report a change, or decertification (move out). The OSSP Application must be completed (typed in Microsoft Word format) by the referring agency and submitted via **encrypted email** to OSP@dc.gov. Prior to submitting the OSSP application, please ensure all sections of the application form are completed. The Department of Health Care Finance DC Optional State Supplemental Program will review the OSSP Application and submit the application to the Social Security Administration for processing. **NOTE:** Any handwritten or incomplete applications will be returned for the referring agency to type or complete and resubmit to OSP@dc.gov.

Section 1: Applicant Information:

The following demographic and income information is needed to complete Section 1: Applicant Information.

- Name: First Name and Last Name
- Social Security Number
- Facility Name
- Facility Address
- Facility Phone Number
- Representative Payee Name and Contact Phone Number
- Please check the appropriate box to indicate if the facility is a CRF or ALF
- Is the applicant receiving SSI? If no, has the applicant filed for SSI?
- What is the amount of the applicant's monthly income?

Section 2: Move- In Information / Certification

The following information is needed when an applicant moves into a CRF/ALF or moves from a CRF/ALF to another CRF/ALF. The information provided will determine the applicant's certification or start date of OSSP benefits. In addition, the Move-In Section provides information of an OSSP beneficiary's move between CRF/ALF locations.

- Check the appropriate box to indicate the facility's bed capacity:
 - OS-A = Adult Foster Care – 50 or fewer beds
 - OS-B = Adult Foster Care – over 50 beds
- Move-In Date: MM/DD/YYYY

- Is the applicant moving from a different CRF or ALF?
- If the applicant moved from another CRF/ALF, please provide the address of the CRF/ALF the applicant moved from. This information helps to track the beneficiaries move between facilities.

Section 3: Move- Out Information / Decertification

The following information is needed when an applicant moves out of a CRF/ALF to an address that is not a CRF/ALF. The information provided in this section will determine the OSSP beneficiary's decertification or end date of OSSP benefits.

- Check the appropriate box to indicate the facility's bed capacity:
 - OS-A = Adult Foster Care – 50 or fewer beds
 - OS-B = Adult Foster Care – over 50 beds
- Move-Out Date: MM/DD/YYYY
- New living situation: Check the applicant's new living situation: Homeless, St. Elizabeth's Hospital, or New Address (home, relative, or address that is not a CRF/ALF)
- If the applicant moved out and is no longer living in a CRF/ALF, please list new address, if applicable

Section 4: Referring Agency Information

- Agency Name and Contact Number
- Name of Person Completing Application, Position/Job Title
- Signature (can be typed)
- Email

Section 5: Remarks

The Remarks Section can be used by the Referring Agency Contact to provide any additional information about the applicant, living status or any other information that may be deemed necessary.

If the Referring Agency has any questions regarding the OSSP Application form or information that is needed to complete the OSSP Application form, please contact Caitlin Brandt, Management Analyst, Division of Eligibility Policy at caitlin.brandt@dc.gov, or Tiffany Davis, Management Assistant, Health Care Policy and Research Administration at tiffany.davis2@dc.gov.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



**To: Department of Health Care Finance
DC Optional State Supplemental Program
441 4th Street NW, Suite 900S
Washington, DC 20001**

Subject: Adult Foster Care Homes (Certified Residential Facility (CRF) or Adult Living Facility (ALF)) Certification or Decertification

Date:

SECTION I: APPLICANT INFORMATION

<i>Name:</i>	<i>Social Security Number:</i>
<i>Facility Name:</i>	<i>Facility Address:</i>
<i>Facility Phone Number:</i>	
<i>Representative Payee Name and Contact Number:</i>	
<i>Please check the appropriate box to indicate if the facility is a</i> <input type="checkbox"/> CRF <input type="checkbox"/> ALF	
<i>Is the applicant receiving SSI? Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>If no, has the applicant filed for SSI: Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/>	
<i>What is the amount of the applicant's monthly income?</i>	

SECTION 2: MOVE IN INFORMATION

The individual identified above resides in an Adult Foster Care Home (CRF/ALF). <input type="checkbox"/> (OS-A) <input type="checkbox"/> (OS-B)
<i>Move in Date</i> (Month, Day, Year):
Is the applicant moving from a different CRF or ALF? Yes <input type="checkbox"/> No <input type="checkbox"/>
If the applicant moved from another CRF/ALF, please provide the address of the CRF/ALF the applicant moved from:

SECTION 3: MOVE OUT INFORMATION

The individual identified above is no longer residing in an Adult Foster Care Home (CRF or ALF).

(OS-A) (OS-B)

Move out date (Month, Day, Year):

New living situation: Homeless St. Elizabeth's Other Hospital New Address

If the applicant moved out and is no longer living in a CRF/ALF, please list new address, if applicable:

SECTION 4: REFERRING AGENCY INFORMATION

Agency Name and Contact Number:

Name of Person Completing Application and Position/Job Title (print):

*Signature**

Email:

By signing this form electronically or in print, you are attesting that the information provided here is true and correct to the best of your knowledge.

SECTION 5: REMARKS

Remarks:

Please complete and submit this form as an encrypted file electronically to osp@dc.gov.

The information contained on this form is privileged or confidential intended only for the use of the individual or entity named above. Unauthorized disclosure or a failure to maintain the confidentiality of this information may be prohibited by State and Federal laws.

For Official Use Only:

Initials of DHCF Representative:

Date: