South Carolina Department of Health and Human Services

SSI RECIPIENT REQUEST FOR OPTIONAL STATE SUPPLEMENTATION (OSS)

1. I, _____, am currently eligible for Supplemental Security Income (SSI).
2. I live or plan to live in a Community Residential Care facility (CRCF).
3. I need help with paying the cost of living in a CRCF.
4. I request this help through the Optional State Supplementation (OSS) program.

The following statements explain your rights and responsibilities. If you do not understand some of the statements, you should discuss the statement(s) with the worker during the interview. You are responsible for giving complete and accurate information.

I understand that I must report any and all changes in my income, living arrangements or other information which will affect my eligibility for OSS within 10 days of the date of the change(s).

I understand that my case record is confidential and no information will be released from it unless properly authorized by me or as provided for under state/federal laws.

I understand that any information I have given is subject to being reviewed by staff members of the Department of Health and Human Services. Also, I understand that I must cooperate fully with state and federal workers if my case is selected for a complete review.

I understand that this request will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief.

I understand that I may request a hearing if I am not satisfied with the action taken on my case or if I feel that I have been discriminated against.

I certify that I have read or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding my situation, I am liable for prosecution for fraud and/or perjury. I hereby give the Department permission to verify, without additional consent from me, information discovered by the Department or given by me that is needed to determine my eligibility for OSS.

Applicant/Responsible Party's Signature: _____ Date: _____

Applicant's Social Security Number: _____ Telephone: _____

Applicant's Address: (Name of facility if already residing in CRCF)

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Worker's Signature: _____ Date: _____