

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)

Worker's Signature: _____ Date: _____

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (including large print, braille, audio, accessible electronic formats, and other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>