RESET FIELDS

APPLICATION FOR PERSONAL CARE HOME SUPPLEMENT

CASE IDENTIFICATION				
CO.	RECORD NUMBER	CAT.	CTR. DIG.	DIST.
CASEWORKER				

1. IDENTIFYING INFORMATION

NAME	SEX ☐ M ☐ F	BIRTHDATE	SOCIAL SECURITY NUMBER
ADDRESS			
APPLYING AS ☐ Individual ☐ Couple	NAME OF SPOUSE (LAST, FIRST, MIDDLE)	BIRTHDATE	SOCIAL SECURITY NUMBER

2. APPLICANT'S AFFIRMATION

I hereby request a State supplement to SSI to enable me to pay for my care in a licensed personal care home of my choice.

For the purpose of determining my need for personal care home care, I authorize the Department of Public Welfare or its agent to obtain such medical and social facts about my situation as may be essential.

_____ _____

(SIGNATURE of Client or Authorized Representative) *(Date)*

3. PERSONAL CARE HOME CERTIFICATION

I hereby certify that the applicant is residing in a licensed personal care home. I have a copy of the current certificate of compliance, a copy of a current medical examination, and a copy of a current social assessment summary (if available) of the above named applicant.

_____

(DATE OF PLACEMENT IN PERSONAL CARE HOME)

_____ _____

(SIGNATURE of Personal Care Home Operator) *(Date)*

4. DATE ASSESSMENT AGENCY RECEIVED THIS FORM FROM THE PERSONAL CARE HOME RESIDENT NOTE: DATE OF RECEIPT AFFECTS DATE OF ELIGIBILITY	DATE _____

5. VERIFICATION BY ASSESSMENT AGENCY

I hereby certify that _____ has been assessed in all of the following areas:
(Resident)

☐ 1. PHYSICAL HEALTH ☐ 3. INTELLECTUAL FUNCTIONING ☐ 5. SOCIAL SUPPORT

☐ 2. ACTIVITIES OF DAILY LIVING ☐ 4. PERSONAL ADJUSTMENT ☐ 6. SOCIAL PARTICPATION

AND

☐ IS FUNCTIONALLY DISABLED – REQUIRES PERSONAL CARE SERVICES IN A RESIDENTIAL SETTING.

OR

☐ IS **NOT** FUNCTIONALLY DISABLED.

REASON:

This verification is based on an evaluation or assessment of the above person within the previous six (6) months. Such evaluation or assessment included face-to-face contact with the person. Documentation of the above is on file and available at:

_____ _____
(Agency) *(Signature)*

_____ _____
(Agency Address) *(Title or Position in Organization)*

_____ _____
(Date)