RESET

APPLICATION FOR DOMICILIARY CARE SUPPLEMENT

CASE IDENTIFICATION				
Co.	Case Number	Cst.	Ctr. Dig.	Dist.
Caseworker				

1. IDENTIFYING INFORMATION

Name (Last, First, Middle)	Sex ☐ M ☐ F	Birthdate	Social Security Number
Address (Street, Town or City, Zip Code)		Applying As: ☐ Individual ☐ Couple	

2. APPLICANT'S AFFIRMATION

I hereby request a State Supplement to SSI to enable me to pay for my care in a certified Domiciliary Care Home of my choice.

For the purpose of determining my need for Domiciliary Care, I authorize the Department of Human Services or its agent to obtain such medical and social facts about my situation as may be essential.

SIGNATURE (Client or Authorized Representative) _____ DATE _____

3. PLACEMENT AGENCY CERTIFICATION

Having reviewed all relevant social and medical information on the above named individual, I certify that the applicant:

☐ NEEDS DOMICILIARY CARE IN AN APPROVED DOMICILIARY CARE HOME AND IS RESIDING.

☐ NEEDS DOMICILIARY CARE IN AN APPROVED DOMICILIARY CARE HOME AND WILL BE RESIDING.

EFFECTIVE DATE:

Name of Home	Phone Number
Address	

SIGNATURE _____ DATE _____

Agency	Phone Number
Address	