TERMINATION

STATE SUPPLEMENT FOR DOMICILIARY

FROM:
COUNTY ASSISTANCE OFFICE
DISTRICT
STREET ADDRESS
CITY OR TOWN ZIP CODE

TO: SOCIAL SECURITY DISTRICT OFFICE
STREET
TOWN OR CITY ZIP CODE

Effective _____ the person named below is no longer eligible for a Domiciliary Care Supplement because of:

- ☐ IMPROVED FUNCTIONING
- ☐ MOVE OUT OF APPROVED FACILITY*
- ☐ MOVE TO A MEDICAID SKILLED NURSING HOME OR INTERMEDIATE CARE FACILITY*
- ☐ MOVE TO A HOSPITAL*
- ☐ DEATH
- ☐ OTHER _____
  (Specify)

NAME	SS NUMBER	WELFARE ID
ADDRESS (Street)		
TOWN OR CITY		ZIP CODE

* NEW ADDRESS IS CURRENT ADDRESS.

_____ _____
SIGNED DATE

_____
TITLE