SSI Assisted Living Arrangement- Category D Verification

To: Social Security Administration
From: Department of Human Services - Medical Assistance Designated Agent

This form serves as an intent for the named individual to file for all potential benefits under the Supplemental Security Income, Title XVI program.

To be completed by the referrer.

I. RESIDENT'S NAME: ____________________________D.O.B ____________

SSN: ____

TELEPHONE NUMBER: ____

PLANNED FACILITY AND
MOVE IN DATE____

CURRENTLY RECEIVING SSI? YES ____NO ____

RESIDENT CONTACT: ____
(PERSON WHO IS HELPING RESIDENT WITH SSI APPLICATION)

PHONE NUMBERS: ____
(INCLUDE DAYS AND TIMES TO BE REACHED)

ADDRESS: ____

To be completed by the Assisted Living Residence.

II. RESIDENCE NAME: ____

ADDRESS: ____

PHONE NUMBER: ____

RESIDENCE CONTACT:____

****CONFIRMED MOVE IN DATE ____________________**

****CHECK IF CHANGE OF RESIDENCE ______________**

*****FOR OFFICE USE ONLY *****

THIS NOTICE IS TO VERIFY THAT THIS RESIDENT HAS BEEN ASSESSED AND REQUIRES ASSISTANCE WITH A MINIMUM OF ONE DAILY TASK SUCH AS MEDICATION MANAGEMENT AND PERSONAL CARE

EFFECTIVE: _____________ _______________ _______________
MONTH DAY YEAR

____ _______________________
SIGNATURE OF MA DESIGNATED AGENT DATE Title

Please return this form to:
Department of Human Services, Center for Adult Health
74 West Road- Hazard Building
Cranston, RI 02920
Fax: 462-3496
Retain a copy for your records

AL-4 2008