SSI ASSISTED LIVING ARRANGEMENT- CATEGORY D VERIFICATION

To: Social Security Administration
From: Department of Human Services-Health Care Quality, Financing & Purchasing
Medical Assistance (MA) Designated Agent

TO BE COMPLETED BY DEPARTMENT OF ELDERLY AFFAIRS (MA DESIGNATED AGENT)

I. **RESIDENT'S NAME :** _____

SSN: _____

TELEPHONE NUMBER: _____

MOVE IN DATE TO FACILITY: _____

CURRENTLY RECEIVING SSI? **YES** _____ **NO** _____

RESIDENT CONTACT: _____
(PERSON WHO IS HELPING RESIDENT WITH APPLICATION)

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

ADDRESS: _____

II. **FACILITY NAME:** _____

ADDRESS: _____

_____

PHONE NUMBER: _____

FACILITY CONTACT: _____

****CHECK IF CHANGE OF FACILITY** _____

THIS NOTICE IS TO VERIFY THAT RHODE ISLAND'S REQUIREMENT FOR SSI LIVING ARRANGEMENT CATEGORY D HAD BEEN MET

EFFECTIVE: _____ _____ _____
MONTH **DAY** **YEAR**

_____ _____
SIGNATURE OF MA DESIGNATED AGENT **DATE**