SSI Community Supportive Living Arrangements --Category F

To: Social Security Administration
From: RI EOHHS/DHS -- Office of Medical Review

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.

Resident's Name:	**Date of Birth:**
SSN #:	**Telephone #:**
Planned Facility and Move-in Date:	
Currently Receiving SSI? Yes ☐ No ☐	
Resident Contact (Person helping with application):	
Telephone # (Include days and times to be reached):	
Address:	

*To be completed by the **CSLP Residence**.*

Residence Name:	**Licensure Type:**
Address:	
Telephone #:	**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 DETERMINED TO REQUIRE THE LEVEL OF SERVICES AND SUPPORT PROVIDED IN A COMMUNITY SUPPORTIVE LIVING PROGRAM RESIDENCE CERTIFIED AS:

Category F ☐ – Community supportive living arrangement providing advanced care

DATE OF DETERMINATION (Month/Day/Year): _____ _____ _____

_____ _____

SIGNATURE OF MEDICAID DESIGNATED AGENT DATE **Title**

_____ _____

BENEFICIARY'S NAME **Date of Birth**

Please return this form to:
Executive Office of Health and Human Services – Office of Medical Review
74 West Road- Hazard Building
Cranston, RI 02920
Retain a copy for your records