



AUTHORIZATION FOR STATE SUPPLEMENT FOR PERSONS IN A DOMICILIARY CARE FACILITY/PERSONAL CARE HOME

INSTRUCTIONS:

1. Prepare form in triplicate. Send original to the appropriate Social Security District Office; second copy to placement agency; retain copy in CAO case record.
2. Complete all identifying data for the individual or each member of a couple.
3. Check block on form to indicate whether authorization is for an individual or for a couple living together in the facility.
4. Check block on form to indicate whether living arrangement is a Domiciliary Care Facility or a Personal Care Home.
5. Enter in "effective date" the 1st day of the month in which the individual or couple was found eligible for the supplement.

LINE NO.	CASE IDENTIFICATION					
	Co	Record Number	Cat	PGM Status	Ctr Dig	Dist

NAME OF INDIVIDUAL (Last, First, M.I.)	SOCIAL SECURITY NO.:	BIRTHDATE: MM DD YY	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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LINE NO.	CASE IDENTIFICATION					
	Co	Record Number	Cat	PGM Status	Ctr Dig	Dist

NAME OF SPOUSE (Last, First, M.I.)	SOCIAL SECURITY NO.:	BIRTHDATE: MM DD YY	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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NAME OF FACILITY:			
ADDRESS:			
STATE SUPPLEMENTATION IS AUTHORIZED FOR THE ABOVE NAMED:	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> COUPLE	IN A <input type="checkbox"/> DOMICILIARY CARE FACILITY <input type="checkbox"/> PERSONAL CARE HOME
			EFFECTIVE DATE:

TO:

Social Security District Office

FROM: ▶

CAO NUMBER	DISTRICT
COUNTY ASSISTANCE OFFICE	
ADDRESS	
CAO WORKER	
PHONE NUMBER ()	