# 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