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| DEPARTMENT OF HEALTH SERVICESDivision of Medicaid ServicesF-20818 (09/2019) | STATE OF WISCONSIN |
|  | Completion of this form is mandatory |
|  | per Wis. Stat. § 49.77 |
| CERTIFICATION FOR SSI-E EXCEPTIONAL EXPENSE SUPPLEMENTPersonally identifiable information collected on this form is confidential and will be used only to determine eligibility for services and for identification purposes. | 1. To: State of Wisconsin Department of Health Services PO Box 6680 Madison, WI 53716-0680 |
|  |  |
| 2. Type [ ]  Natural Residential (NR) [ ]  Substitute Care (SC) | 3. Action [ ]  Start [ ]  Stop (decertification-answer question 12) | 4. SSI-E Effective Date |
|  |  |  |    | / |    | / |      |  |
|  |  |  mo. day full year |
| 5. Name - Applicant (Last, First, MI) | 6. Social Security Number      |
|       |       |       |  |
| 7. Applicant Address      | 8. Date of Birth | 9. Telephone Number      |
|  |  |    | / |    | / |      |  |  |
|  |  mo. day full year |  |
|  | 12. If **STOPPED**, Decertification Reason | Date Stopped      |
|  | [ ]  Institutionalized more than 90 days[ ]  Living arrangement no longer qualifies[ ]  No longer receives/needs qualifying amount/type of services[ ]  Death[ ]  Moved out of state[ ]  Financially ineligible (for grandfathered individuals)[ ]  Changed county of responsibility[ ]  Other—Specify:       |
| 10. County of Residence      |  |
| 11. Age/Disability Group[ ]  Elderly (65+)[ ]  Physically disabled[ ]  Alzheimer’s/other dementia | [ ]  Developmental disabilities[ ]  Mental Health[ ]  AODA |  |
| **I CERTIFY**, this information is correct and the action is in accordance with Wis. Stat. § 49.77.Re: Federal regulations 20 CFR 416 |
| 13. Name – Worker      | 14. Date Form Completed      | 15. Worker Telephone Number      |
| 16. **SIGNATURE** - Agency Director or Designee | 17. Name - Representative Payee (if any)      |
| 18. Agency Name and Address      | 19. Representative Payee Address      |
|  | 20. Date Approved      |
| 21. Living Arrangement Upon Certification |
| [ ]  Foster home for children | [ ]  CBRF over 20 beds and is a certified independent apartment or w/approved variance |
| [ ]  Group home for children | [ ]  Grandfathered CBRF 20 or more beds (Name) |
| [ ]  Licensed or certified adult family home | [ ]  Person’s own home or apartment |
| [ ]  CBRF (8 beds or less) | [ ]  Home/apartment of another |
| [ ]  CBRF (9-20 beds) | [ ]  Other—Specify:        |

I understand that signing this form means I am applying for the SSI-E Exceptional Expense Supplement.

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| **SIGNATURE**  - Applicant/Representative  |  Application Date | If Representative, Relationship to Applicant |

ACTION TAKEN

SSI-E CERTIFICATION

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|  [ ]  I have processed this certification. [ ]  I have not processed this certification. (Reason(s) |
| **SIGNATURE** - State SSI Unit Worker | Date Signed |