AUTHORIZATION FOR NONMEDICAL OUT– OF– HOME CARE (BOARD AND CARE)

(SSA COMPLETES ALL BUT SECTION 'B')

DATE

APPLICANT/RECIPIENT'S NAME	SEX ☐ M ☐ F	DATE OF BIRTH	SOCIAL SECURITY NUMBER
APPLICANT/RECIPIENT'S HOME ADDRESS		RECEIVING IHSS	TELEPHONE NUMBER

☐ AGED
☐ BLIND
☐ DISABLED TYPE OF DISABILITY

REASON FOR CERTIFICATION
☐ CHANGE OF ADDRESS ☐ CHANGE OF LIVING ARRANGEMENT ☐ OTHER _____

I. SSA OFFICE REQUEST TO COUNTY WELFARE DEPARTMENT FOR CERTIFICATION

ADDRESS FOR WINDOW ENVELOPE

TO

SSA REPRESENTATIVE REQUESTING INFORMATION
NAME
TITLE
TELEPHONE NUMBER

A. SSA OFFICE REQUEST

The above-named person may be entitled to the nonmedical out-of-home care benefit level in the home of a relative or a facility. (MPP Section 46-140)

NAME OF RELATIVE	RELATIONSHIP	**OR**	FACILITY

Please certify whether or not this person is receiving nonmedical out-of-home care.

B. COUNTY WELFARE DEPARTMENT RESPONSE
I certify that the above named

☐ IS NOT receiving nonmedical out-of-home care as authorized under DSS MPP Section 46-140.

☐ IS receiving nonmedical out-of-home care as authorized under DSS MPP Section 46-140 in the arrangement described below.

CHECK ONE:

☐ a. The home of a relative or legally appointed guardian or conservator, or,
☐ b. A certified family home or foster family home

EFFECTIVE *(See Reverse)*

___/___/___
MONTH DAY YEAR

SIGNATURE OF CERTIFYING COUNTY REPRESENTATIVE	TITLE	TELEPHONE	DATE
SIGNATURE OF SUPERVISOR	TITLE	TELEPHONE	DATE

II. SSA OFFICE VERIFICATION OF LICENSED CARE FACILITIES CASE

A. I have verified that the above-named person lives in a licensed nonmedical out-of-home care facility, license number
The effective date of the living arrangement is ___/___/___
MONTH DAY YEAR

Current residency was confirmed with _____
NAME TITLE

B. Licensure was verified by:
☐ List supplied by State Department of Social Services.
☐ Telephone contact with _____
☐ Other (specify) _____

SIGNATURE OF REPRESENTATIVE	TITLE	OFFICE	DATE

ADDRESS FOR WINDOW ENVELOPE

RETURN TO

OFFICE

COUNTY INSTRUCTIONS

When the county cannot obtain material evidence that the individual needed and was receiving care in the living arrangement continuously from an earlier date, have the client complete the statement below. When this is necessary, the county will enter the date to which the client has attested in the **"EFFECTIVE"** section of Part B. on the authorization form.

NOTE: MPP Section 46-140.65 limits the earlier date for an individual who is already receiving SSI/SSP to the month in which the care began or three (3) months from the month the County is asked to certify the NMOHC living arrangement, whichever is later.

CLIENT STATEMENT FOR RETROACTIVE CERTIFICATIONS.

I certify that I have been in my current living arrangement with my _____ since
RELATIONSHIP

_____ .
DATE

I AGREE TO IMMEDIATELY NOTIFY SOCIAL SECURITY IF THERE IS ANY CHANGE IN MY CURRENT LIVING ARRANGEMENT.

APPLICANT/RECIPIENT SIGNATURE ▶	SOCIAL SECURITY NUMBER	DATE