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| DEPARTMENT OF HEALTH SERVICES Division of Medicaid Services  F-20818 (09/2019) | | | | | | STATE OF WISCONSIN | | | | | | | | | | | | | | | | |
|  | | | | | | Completion of this form is mandatory | | | | | | | | | | | | | | | | |
|  | | | | | | per Wis. Stat. § 49.77 | | | | | | | | | | | | | | | | |
| CERTIFICATION FOR SSI-EEXCEPTIONAL EXPENSE SUPPLEMENT Personally 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

ACTION TAKEN

SSI-E CERTIFICATION

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