

**CERTIFICATION FOR SSI-E
 EXCEPTIONAL EXPENSE SUPPLEMENT**

1. To: State of Wisconsin
 Department of Health Services
 P.O. Box 6680
 Madison, WI 53716-0680

Personally identifiable information collected on this form is confidential and will be used only to determine eligibility for services and for identification purposes.

2. Type <input type="checkbox"/> Natural Residential (NR) <input type="checkbox"/> Substitute Care (SC)	3. Action <input type="checkbox"/> Start <input type="checkbox"/> 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 ____ / ____ / ____ mo. day full year	9. Telephone Number
10. County of Residence	12. If STOPPED , Decertification Reason <input type="checkbox"/> Institutionalized more than 90 days <input type="checkbox"/> Living arrangement no longer qualifies <input type="checkbox"/> No longer receives/needs qualifying amount/type of services <input type="checkbox"/> Death <input type="checkbox"/> Moved out of state <input type="checkbox"/> Financially ineligible (for grandfathered individuals) <input type="checkbox"/> Changed county of responsibility <input type="checkbox"/> Other—Specify: _____	
11. Age/Disability Group <input type="checkbox"/> Elderly (65+) <input type="checkbox"/> Developmental disabilities <input type="checkbox"/> Physically disabled <input type="checkbox"/> Mental Health <input type="checkbox"/> Alzheimer's/other dementia <input type="checkbox"/> AODA	Date Stopped _____	

I CERTIFY, this information is correct and the action is in accordance with sec. 49.77, Wis. Stats.
 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 <input type="checkbox"/> Foster home for children <input type="checkbox"/> CBRF over 20 beds and is a certified independent apartment or w/approved variance <input type="checkbox"/> Group home for children <input type="checkbox"/> Grandfathered CBRF 20 or more beds (Name) <input type="checkbox"/> Licensed or certified adult family home <input type="checkbox"/> Person's own home or apartment <input type="checkbox"/> CBRF (8 beds or less) <input type="checkbox"/> Home/apartment of another <input type="checkbox"/> CBRF (9-20 beds) <input type="checkbox"/> 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
