

**AUTHORIZATION FOR NONMEDICAL OUT- OF- HOME CARE  
(BOARD AND CARE)  
(SSA COMPLETES ALL BUT SECTION 'B')**

DATE \_\_\_\_\_

APPLICANT/RECIPIENT'S NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	SOCIAL SECURITY NUMBER
APPLICANT/RECIPIENT'S HOME ADDRESS	RECEIVING IHSS	TELEPHONE NUMBER	
<input type="checkbox"/> AGED <input type="checkbox"/> BLIND <input type="checkbox"/> DISABLED TYPE OF DISABILITY	REASON FOR CERTIFICATION <input type="checkbox"/> CHANGE OF ADDRESS <input type="checkbox"/> CHANGE OF LIVING ARRANGEMENT <input type="checkbox"/> 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	<b>OR</b>	FACILITY
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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
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ADDRESS FOR WINDOW ENVELOPE	<b>RETURN TO</b>	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  
DATE RELATIONSHIP

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

APPLICANT/RECIPIENT SIGNATURE	SOCIAL SECURITY NUMBER	DATE
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