Iowa Department of Human Services

CERTIFICATION OF ELIGIBILITY OF SSI APPLICANT

From/To DHS County Office	From/To SSA Office	Date

A. Identification ☐ Aged ☐ Blind ☐ Disabled

Applicant Last Name	First Name	Middle	Birth Date (MM/DD/YY)	
Street	**City**		**State**	**Zip Code**
☐ Male ☐ Female Citizen: ☐ Yes ☐ No	**Telephone No.**	**Social Security No.**	**Social Security Claim No.**	

Check one, if applicable.
Write name and address below. ☐ Representative payee ☐ Guardian ☐ Conservator

Last Name	First	Middle	Telephone No.	
Street	**City**		**State**	**Zip Code**

B. Eligibility Status:

Month and year of first eligibility for payment for:

SSI: Month_____ Year_____ State Supplemental: Month_____ Year_____

Type of Living Arrangement (check one)

☐ Own home ☐ Residential care
☐ Own home with dependent person ☐ Family life home
☐ Home of another ☐ Other: _____
☐ Medical institution: Name: _____ Date entered _____

Type: ☐ Hospital ☐ Skilled Nursing ☐ Nursing Facility

Address: Street	City	State	Zip Code

Gross monthly income: Social Security $_____ Other $_____

Does the applicant have unpaid medical bills incurred in the three months before the date of SSI eligibility? ☐ Yes ☐ No

C. Remarks

Explain forced pay, one-time pay, limited period of eligibility, emergency medical need, or other pertinent information.

D. Certification by SSA Office

I certify that the above information is correct according to records.

Signature	Date