Department of HUMAN SERVICES

State Supplementary Assistance Certification or Termination

From:
To:

The Department of Human Services has taken action to certify or to terminate optional State Supplementary Assistance benefits for this client. Please complete page 2 of this form and return it to the sending office.

1. CLIENT IDENTIFICATION

Name	SSN	Case Number
Address		Phone
Current SSI Recipient? ☐ Yes ☐ No ☐ Unknown ☐ Aged ☐ Blind ☐ Disabled		
Representative Name	☐ Conservator ☐ Payee ☐ Guardian	
Address		Phone
Contact Person Name		Relationship
Address		Phone

2. CERTIFICATION

☐ Dependent Person ☐ Family-Life Home	Effective Date	
Dependent Name	Age	Relationship
Family-Life Home Name		

3. TERMINATION

Date:	Cause: ☐ Death ☐ Removal of Dependent ☐ Client Left

4. COMMENTS

IM Signature	Date
Service Signature	Date

Department of HUMAN SERVICES

To be completed by the Social Security Administration

Return to Imaging Center:

1. CLIENT INCOME INFORMATION

SSN:
Case #:

Source	Amount
Total Gross Monthly Income	

2. SSI ELIGIBILITY DECISION

☐ Approved effective _____.

☐ Not applicable. Client is already receiving SSI.

☐ Denied because:

3. STATE SUPPLEMENTARY PAYMENT DECISION

☐ Approved for payment effective _____.

☐ Denied because:

4. TERMINATION

State supplement payment has been terminated effective _____.

SSA Signature	Office	Date