



3 West Road | Virks Building | Cranston, RI 02920

### Attachment 4 - SSI Community Supportive Living Arrangements - Category F

To: Social Security Administration

From: RI EOHHS/DHS -- Office of Community Programs

This form serves as an intent for the named individual to file for all potential benefits under the Supplemental Security Income, Title XVI program.

*To be completed by the referrer.*

Resident's Name:	Date of Birth:
SSN #:	Telephone#:
Planned Facility and Move-in Date:	
Currently Receiving SSI? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Resident Contact (Person helping with application):	
Telephone# (Include days and times to be reached):	
Address:	

*To be completed by the Assisted Living Residence.*

Residence Name:	Licensure Type:
Address:	
Telephone#:	Residence Contact:
Confirmed Move-in Date:	Check if Change of Residence: <input type="checkbox"/>

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\*\*\*FOR OFFICE USE ONLY\*\*\*

**THIS NOTICE IS TO VERIFY THAT THIS RESIDENT HAS BEEN ASSESSED AND DETERMINED TO REQUIRE THE LEVEL OF SERVICES AND SUPPORT PROVIDED IN A COMMUNITY SUPPORTIVE LIVING PROGRAM RESIDENCE CERTIFIED AS:**

Category F  - Community supportive living arrangement providing advanced care

**DATE OF DETERMINATION (Month/ Day/ Year):** \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF MEDICAID DESIGNATED AGENT DATE** **Title**

\_\_\_\_\_  
**BENEFICIARY'S NAME** **Date of Birth**

Please return this form to:

Executive Office of Health and Human Services - Office of Community Programs  
3 West Rd, Virks Building  
Cranston, RI 02920  
Retain a copy for your records