

AUTHORIZATION FOR NONMEDICAL OUT-OF-HOME CARE (BOARD AND CARE)

(SSA COMPLETES ALL BUT SECTION "B")

DATE			
APPLICANT/CLAIMANT'S NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
APPLICANT/RECEPIENT'S HOME ADDRESS	RECEIVING IHHS <input type="checkbox"/> YES <input type="checkbox"/> NO		TELEPHONE NUMBER
REASON FOR CERTIFICATION			
<input type="checkbox"/> AGED	<input type="checkbox"/> CHANGE OF ADDRESS	<input type="checkbox"/> CHANGE IN LIVING ARRANGEMENTS	<input type="checkbox"/> OTHER
<input type="checkbox"/> BLIND			
<input type="checkbox"/> DISABLED TYPE OF DISABILITY			

TO: COUNTY OF SAN DIEGO  
HEALTH & HUMAN SERVICES  
780 BAY BLVD, STE 200  
CHULA VISTA, CA 91910

FROM: Anita Borrero  
TITLE: CLAIMS REPRESENTATIVE  
TELEPHONE: 427-7414 EXT \_\_\_\_

I SSA OFFICE REQUEST TO COUNTY WELFARE DEPARTMENT FOR CERTIFICATATION

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 46.325.311 b and c)

NAME OF RELATIVE	RELATIONSHIP	OR	FACILITY

PLEASE CERTIFY WHETHER OR NOT THIS PERSON IS RECEIVING NONMEDICAL OUT-OF-HOME CARE

B. COUNTY WELFARE DEPARTMENT RESPONSE:

I certify the above named  
\_\_\_ Is NOT receiving nonmedical out-of-home care as authorized under DSS MPP Section 46-325.311  
\_\_\_ IS receiving nonmedical out-of-home care as authorized under DSS MPP Section 46-325.311 in the arrangement described below

CHECK ONE

- \_\_\_ The home of a relative or legally appointed guardian or conservator or,
- \_\_\_ A home in which a child has been place by a court order under California W and I Code 727(a) or,
- \_\_\_ An "exclusive use home" approved by a licensed home funding agency.

SIGNATURE OF CERTIFYING COUNTY REPRESENTATIVE	TITLE	TELEPHONE	DATE
SIGNATURE OF SUPERVISOR	TITLE	TELEPHONE	DATE

II SSA OFFICE VERFICATION OF LICENSED BOARD AND CARE FACILITY

A I have verified the above named person lives in a licensed nonmedical out-of-home facility, license number  
The effective date of the living arrangement is (date)  
Current residency was confirmed with (name/title)  
B Licensure was verified by:  List supplied by Social Servicoes  Telephone contact with

SIGNATURE OF CERTIFYING SSA REPRESENTATIVE	TITLE	OFFICE	DATE