DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-20818 (09/2019)

STATE OF WISCONSIN
Completion of this form is mandatory
per Wis. Stat. § 49.77

CERTIFICATION FOR SSI-E EXCEPTIONAL EXPENSE SUPPLEMENT

Personally identifiable information collected on this form is confidential and will be used only to determine eligibility for services and for identification purposes.

1. To: State of Wisconsin
Department of Health Services
PO Box 6680
Madison, WI 53716-0680

2. Type
☐ Natural Residential (NR)
☐ Substitute Care (SC)

3. Action
☐ Start
☐ Stop (decertification-answer question 12)

4. SSI-E Effective Date
____ / ____ / ____
mo. day full year

5. Name - Applicant (Last, First, MI)

6. Social Security Number

7. Applicant Address

8. Date of Birth
____ / ____ / ____
mo. day full year

9. Telephone Number

10. County of Residence

11. Age/Disability Group
☐ Elderly (65+)
☐ Physically disabled
☐ Alzheimer's/other dementia
☐ Developmental disabilities
☐ Mental Health
☐ AODA

12. If **STOPPED**, Decertification Reason

Date Stopped

☐ Institutionalized more than 90 days
☐ Living arrangement no longer qualifies
☐ No longer receives/needs qualifying amount/type of services
☐ Death
☐ Moved out of state
☐ Financially ineligible (for grandfathered individuals)
☐ Changed county of responsibility
☐ Other—Specify: _____

I CERTIFY, this information is correct and the action is in accordance with Wis. Stat. § 49.77.
Re: Federal regulations 20 CFR 416

13. Name – Worker

14. Date Form Completed

15. Worker Telephone Number

16. **SIGNATURE** - Agency Director or Designee

17. Name - Representative Payee (if any)

18. Agency Name and Address

19. Representative Payee Address

20. Date Approved

21. Living Arrangement Upon Certification
☐ Foster home for children
☐ Group home for children
☐ Licensed or certified adult family home
☐ CBRF (8 beds or less)
☐ CBRF (9-20 beds)
☐ CBRF over 20 beds and is a certified independent apartment or w/approved variance
☐ Grandfathered CBRF 20 or more beds (Name)
☐ Person's own home or apartment
☐ Home/apartment of another
☐ Other—Specify: _____

I understand that signing this form means I am applying for the SSI-E Exceptional Expense Supplement.

SIGNATURE - Applicant/Representative

Application Date

If Representative, Relationship to Applicant

Two Copies: State of Wisconsin
DHS
PO Box 6680 Madison,
WI 53716-0680

One Copy: Applicant

One Copy: Agency Case Record

ACTION TAKEN

SSI-E CERTIFICATION

☐ I have processed this certification.

☐ I have not processed this certification.

(Reason(s)

SIGNATURE - State SSI Unit Worker	Date Signed