CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI) NONMEDICAL OUT-OF-HOME CARE (NMOHC) PAYMENT STANDARD ELIGIBILITY DETERMINATION (SOC 887)

Use this form for initial NMOHC determinations and redeterminations.

County of _____ Date: _____

SECTION A: CLAIMANT INFORMATION

Name: Date of Birth: Case Number:

_____ _____ _____

Address:

_____

Date claimant began living at the above address _____ (MM/DD/YYYY)

Reason for Certification:

Change of Address Change of Living Arrangement New Applicant Redetermination

Is the claimant receiving assistance with personal care or hygiene or with the upkeep of their residence (e.g., help with eating, dressing, bathing, toileting, ambulation, transferring, medication management, money management, transportation, meal preparation, laundry, arranging medical/ dental care, accessing community resources, and/or housework)? Yes No

Does claimant currently receive IHSS? Yes No

SECTION B: LIVING ARRANGEMENT

Does claimant live with a Relative, a Legal Guardian, Conservator, or in a Licensed Facility?

Yes No

Name of Relative / Relationship, Legal Guardian/Conservator OR Name of Facility:

_____

Is NMOHC being provided by the person or facility listed above? Yes No

If NO, write the name of the Relative (also identify relationship) or Facility providing NMOHC:

_____

Date claimant began receiving non-medical out-of-home care services:

_____ (MM/DD/YYYY)

Does claimant have rental liability (e.g., is claimant's name listed on the lease) or own the home in which they live? Yes No

Does claimant live with spouse who is receiving SSI/SSP? Yes No

SECTION C: NMOHC VERIFICATION

Verified valid living arrangement with a relative? Yes No

Document(s) supporting the living arrangement:

_____

Effective date of the NMOHC living arrangement: _____ (MM/DD/YYYY)

OR

Verified valid living arrangement at a licensed facility? Yes No

Document(s) supporting the living arrangement:

_____

Effective date of the NMOHC living arrangement: _____ (MM/DD/YYYY)

Licensure was verified by:

CDSS Community Care Licensing Division (CCLD); or
Telephone contact with CDSS-CCLD representative.

Representative's Name: Title:

_____ _____

Phone Number:

_____

SECTION D: DETERMINATION

Based on the information summarized on this form, it is determined that the NMOHC CAPI Payment Standard:

"Licensed Facility or Without In-kind Room & Board" applies
"With In-Kind Room & Board" applies
Does not apply

Eligibility Worker Signature: Date:

_____ _____

Supervisor Signature: Date:

_____ _____