DPHHS-SLTC-109
(Rev. 11/03)

STATE OF MONTANA
Department of Public Health and Human Services
Senior and Long Term Care Division

SUPPLEMENTAL SECURITY INCOME
TERMINATION OF STATE SUPPLEMENTAL PAYMENT

SENT TO: **Social Security District Office** _____
(City)

(Name of Individual) (Social Security Number) (Date of Birth)

(Name of Facility) (Street Address)

(Mailing Address)

1. **Monthly SSI State Supplemental Payment to the above individual ends/ended effective:**

   Last day of month of: _____ **Year:** _____

2. **Reason for termination:**

   ☐ **Individual died (month/day/year):** _____

   ☐ **Individual no longer residing in licensed Personal Care Facility**

   ☐ **Individual no longer residing in licensed Adult Foster Home**

   ☐ **Individual no longer residing in licensed Child Foster Home or Group Home**

   ☐ **Individual no longer residing in licensed Group Home for the Mentally Disabled**

   ☐ **Individual no longer residing in licensed Group Home for the Developmentally Disabled**

   ☐ **Individual no longer residing in approved Transitional Living Services for the Developmentally Disabled**

   ☐ **Individual no longer residing in licensed Group Home for the Severely Disabled**

   ☐ **Individual has excess income or resources.**

   ☐ **Other:** _____

3. **New address of individual:**

   _____
   (Residence Address) (City, State, Zip) (Phone Number)

4. **Does this individual have a representative payee?** ☐Yes ☐ No

   Does this individual need a representative payee? ☐Yes ☐ No
   If "Yes", who do you recommend? (List below)

   If individual has a representative payee, is that payee still in the best position to serve the individuals interest? ☐Yes ☐ No

   If "No", who do you recommend as the new payee? ☐Yes ☐ No

   _____
   (Name) (Address)

5. **CERTIFICATION:** **Case terminated from State Supplemental Payment level:** _____

   _____
   (Printed name of DPHHS Employee/Representative) (Title) (Phone Number)

   _____
   (Agency Name) (Address) (City, State, Zip Code)

   _____
   (Signature of DPHHS Employee/Representative) (Date)

NOTE: **Send yellow copy to: SSP Program, Senior & Long Term Care Division, P.O. Box 4210, Helena, MT 59604-4210.**

Distribution: White-Social Security District Office; Yellow-SLTC; Pink-Originator