DHS-390, ADULT SERVICES APPLICATION

Michigan Department of Health and Human Services (Revised 10-21)

| Note: If you need help to complete this application, p ☐ Bilingual Interpreter ☐ Sign-land ☐ Other (specify) | lease indicate what kind of help you need. guage interpreter for the deaf | | |
|---|---|--|--|
| FOR DEPARTMENTAL USE ONLY | | | |
| 1. Case Name | 2. Log Number 3. Recipient ID Number | | |
| 4. County | 5. Date | | |
| 6. Worker | 7. Worker Phone Number | | |
| CLIENT INFORMATION | | | |
| 8. Full Name of Person Needing or Requesting Servi | ces | | |
| 9. Date of Birth (MM/DD/YYYY) | 10. Social Security Number | | |
| 11. Address (Number, Street, City, State, Zip Code) | | | |
| 12. Phone or Cell Number | 13. TTY Number (Teletype for the deaf) | | |
| SECTION A – DEPARTMENT PROGRAMS: Below is the Department. Check the box or boxes which described desire help. | | | |
| Home Help Services to help pay for someone to assist wire | th personal care and housekeeping. | | |
| 2. Adult Community Placement Services for adults who can no longer remain foster home or home for the aged and services | in their own homes. Includes help finding an adult s for people living in these settings. | | |
| 3. Other Services Nonpayment services to help adults stay safe information and referral to other community re | • | | |
| IF YOU OR SOMEONE YOU KNOW IS IN NI CENTRALIZED INTAKE FOR ABUSE OR N | EED OF PROTECTIVE SERVICES, CONTACT EGLECT AT 855-444-3911. | | |
| SECTION B - CURRENT SITUATION: Check all box | es that apply to you. | | |
| Your Status as a Recipient X Medicaid (MA) recipient Medicaid application pending Medicaid application pending Supplemental Security Income (SSI) recipient MI Choice Waiver recipient PACE recipient MI Health Link recipient | ent | | |

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| | g. | Community Mental Health (CMH) recipient | |
|--|------|--|--|
| | h | Food Assistance recipient | |
| | i. | Family Independence Program (FIP) recipient | |
| | j. | State Disability Assistance (SDA) recipient | |
| | k. | ☐ Veteran Affairs recipient | |
| | l. | Other | |
| 2. | Liv | ing Arrangement (Check all boxes that apply to you and answer related questions) | |
| | a. | Alone | |
| | b. | ☐ With spouse (If married answer questions below.) | |
| | | Is spouse disabled? | |
| | | Is spouse working? | |
| | | Full name of spouse Date of Birth | |
| | C. | ☐ With children under age 18. How many? | |
| | d. | ☐ With others (relatives and non-relatives) How many? | |
| | e. | Live in adult foster care facility, home for the aged. | |
| | f. | Is client in a hospital or nursing home? | |
| | g. | Does the recipient have a guardian? | |
| | | Name of guardian | |
| | h. | Is a caregiver/provider already identified? | |
| Re | ad t | the following statement, sign, and date the application. | |
| | | to apply for one of the adult services programs. I certify that the information I have given is correct. | |
| By signing, I acknowledge that I have read and agree to the rights, responsibilities, and important things | | | |
| to know described in Section C of this application. | | | |
| | | | |
| ΣlΩ | gnat | ure of Client or Authorized Representative Date | |
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