

MS 08110.009 Institution Residence Facsimiles and Screen Shots

The Institution Residence Data (LINS) page reference has changed to MS 08110.009 due to MSOM updates. When continued payments are payable for temporary institutionalization, SSA must receive a physician’s certification and home expenses statement by the recipient, no later than the date of discharge or the 90th day of medical confinement, whichever is earlier.

The SSA Claims Specialist (CS) confirms the recipient and physician provided this required information by completing the fields ‘Home expense statement date’ field and ‘Physician certification date’ field on the Screenshot page ‘Institution Residence – TI Benefits Selected’. These fields tell the SSI system that the CS has obtained the necessary documentation to determine the SSI recipient is eligible for temporary institutionalization benefits.

These fields serve as a safeguard to prevent the issuance of incorrect payments to a recipient who does not meet the requirements to receive temporary institutionalization benefits.

FACSIMILE 1: INSTITUTION RESIDENCE – LEVINGS STATE (MEETS LEVINGS REQUIREMENTS IS YES)

INSTITUTION RESIDENCE

NAME	SOCIAL SECURITY NUMBER(SSN)	ROLE
SSSSSSSSSSSSSSSSSSSSSS	SSSSSSSSSSSSSSSSSSSSSS	SSSSSSSSSSSSSSSSSSSSSS
SSSS	SSSS	SSS-SS-SSSS

[\[1-D\]](#)

PERIOD EFFECTIVE DATES SS/SS/SSSS – SS/SS/SSSS

*INDICATES REQUIRED INFORMATION

INSTITUTION FAVORITES

SELECT FROM FAVORITES OR TYPE CONTACT INFORMATION

[\[2-O\]](#)

[v/^] SHOW/HIDE FAVORITES

INSTITUTION FAVORITES

[\[3-O\]](#)

[\[4-O\]](#)

[REFRESH]

MANAGE OFFICE LEVEL FAVORITES

[\[5-D\]](#) [\[6-D\]](#) [\[7-D\]](#) [\[8-O\]](#)
INSTITUTION NAME ADDRESS PHONE ACTIONS
SS[VARIABLES]SS SS[VARIABLES]SS SS[VARIABLES]SS [SELECT]

[\[9-M\]](#)
*INSTITUTION NAME
XXX [] UNKNOWN

*ADDRESS

[\[10-M\]](#)
*COUNTRY:
--

[\[11-M\]](#) [\[12-O\]](#) [\[14-O\]](#) [\[15-O\]](#)
*STREET 1 STREET 2 STREET 3 STREET 4

[\[16-M\]](#) [\[17-C\]](#) [\[18-C\]](#) [\[19-C\]](#)
*CITY/TOWN: STATE/TERRITORY STATE/PROVINCE/REGION ZIP
CODE

[\[20-C\]](#) [\[21-O\]](#)
POSTAL CODE [] UNKNOWN

[\[22-O\]](#) [\[23-O\]](#) [\[24-O\]](#)
PHONE:()U.S. ()INTERNATIONALPHONE: PHONE PHONE
(999)999-9999 (DOMESTIC) 99[MAX 15 CHARACTERS]99
(INTERNATIONAL)

10-DIGIT NUMBER/COUNTRY CODE + NUMBER

[\[25-D\]](#)
DATE INSTITUTIONALIZATION BEGAN SS/SS/SSSS

[\[26-C\]](#)

*MEDICAID, OR MEDICARE PART A WITH STATE BUY-IN, PAYS MORE THAN 50%

YES NO UNKNOWN

[\[27-C\]](#)

MONTHLY CHARGE 9999.99 UNKNOWN

[\[28-C\]](#)

AMOUNT CLAIMANT PAYS 9999.99 UNKNWON

[\[29-C\]](#)

*INSTITUTION FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) PURPOSES

YES NO

[\[30-C\]](#)

[\[31-O\]](#)

*MEETS LEVINGS REQUIREMENTS MORE INFO

YES NO DECIDE LATER

[\[32-O\]](#)

SHOW/HIDE PERSON REMARKS

[\[33-O\]](#)

PERSON REMARKS (PRINTED)

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[34-O\]](#)

SHOW/HIDE FILE DOCUMENTATION NOTES

[\[35-O\]](#)

FILE DOCUMENTATION NOTES

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[36-O\]](#)

[CLEAR PAGE/UNDO CHANGES]

F. SCREENSHOT 1: INSTITUTION RESIDENCE - LEVINGS STATE (MEETS LEVINGS REQUIREMENTS IS YES)

Institution Residence

Name	Social Security Number (SSN)	Role
		Claimant

Period Effective Dates: 01/01/2018 - Continuing

Living Arrangements

- Periods
- 01/01/2018 - Continuing
- Residence Address and Jurisdiction
- Institution Residence
- In-Kind Support and Maintenance
- Living Arrangement Change

* Indicates required information

Select from favorites or type contact information

[Show favorites](#)

* Institution name Unknown

* Address

* Country

* Street 1

Street 2

Street 3

Street 4

* City/Town

* State/Territory

* ZIP Code

Unknown

Phone

U.S. International

10-digit Number

Date institutionalization began 01/01/2010

* Medicaid, or Medicare Part A with state buy-in, pays more than 50%

Yes No Unknown

* Institution for Supplemental Nutrition Assistance Program (SNAP) purposes

Yes No

* Meets Levings requirements [More Info](#)

Yes No Decide later

[Show person remarks](#)

No remarks

[Show file documentation notes](#)

No notes

[Undo Changes](#)

G. FACSIMILE 2: INSTITUTION RESIDENCE (MEETS LEVINGS REQUIREMENTS IS NO)

INSTITUTION RESIDENCE

NAME	SOCIAL SECURITY NUMBER(SSN)	ROLE
SSSSSSSSSSSSSSSSSSSSSS SSSSSSSSSSSSSSSSS SSSSSSSSSSSSSSSSSSSSS SSSS	SSSS-SS-SSSS	
SSSS	SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS	

[\[1-D\]](#)

PERIOD EFFECTIVE DATES SS/SS/SSSS – SS/SS/SSSS

*INDICATES REQUIRED INFORMATION

INSTITUTION FAVORITES

SELECT FROM FAVORITES OR TYPE CONTACT INFORMATION

[\[2-O\]](#)

[v/^] SHOW/HIDE FAVORITES

INSTITUTION FAVORITES

[\[3-O\]](#)

[\[4-O\]](#)

[REFRESH]

MANAGE OFFICE LEVEL FAVORITES

[\[5-D\]](#)

[\[6-D\]](#)

[\[7-D\]](#)

[\[8-O\]](#)

INSTITUTION NAME	ADDRESS	PHONE	ACTIONS
SS[VARIABLES]SS	SS[VARIABLES]SS	SS[VARIABLES]SS	[SELECT]

[\[9-M\]](#)

*INSTITUTION NAME

XX [] UNKNOWN

*ADDRESS

[\[10-M\]](#)

*COUNTRY:

--

[\[11-M\]](#)

[\[12-O\]](#)

[\[14-O\]](#)

[\[15-O\]](#)

*STREET 1

STREET 2

STREET 3

STREET 4

[\[16-M\]](#)

[\[17-C\]](#)

[\[18-C\]](#)

[\[19-C\]](#)

*CITY/TOWN:
CODE

STATE/TERRITORY

STATE/PROVINCE/REGION

ZIP

[\[20-C\]](#)

[\[21-O\]](#)

POSTAL CODE

UNKNOWN

[\[22-O\]](#)

[\[23-O\]](#)

[\[24-O\]](#)

PHONE: () U.S. () INTERNATIONAL PHONE: PHONE

PHONE

(999)999-9999 (DOMESTIC) 99 [MAX 15
CHARACTERS] 99 (INTERNATIONAL) 10-DIGIT NUMBER/COUNTRY CODE +
NUMBER

[\[25-D\]](#)

DATE INSTITUTIONALIZATION BEGAN SS/SS/SSSS

[\[26-C\]](#)

*MEDICAID, OR MEDICARE PART A WITH STATE BUY-IN, PAYS MORE THAN 50%

() YES () NO () UNKNOWN

[\[27-C\]](#)

MONTHLY CHARGE 9999.99 UNKNOWN

[\[28-C\]](#)

AMOUNT CLAIMANT PAYS 9999.99 UNKNWON

[\[29-C\]](#)

*INSTITUTION FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
PURPOSES

() YES () NO

[\[30-C\]](#)

[\[31-O\]](#)

*MEETS LEVINGS REQUIREMENTS MORE INFO

YES NO DECIDE LATER

[\[40-D\]](#)

[\[41-C\]](#)

ADMISSION DATE SS/SS/SSSS

*ADMISSION DATE VERIFIED

YES NO

[\[42-O\]](#)

DISCHARGED FROM THE INSTITUTION

[\[43-C\]](#)

[\[44-C\]](#)

*DISCHARGE DATE 99/99/9999
MM/DD/YYYY

*DISCHARGE DATE VERIFIED

YES NO

[\[45-C\]](#)

*INSTITUTION TYPE

PUBLIC PRIVATE UNKNOWN

[\[46-C\]](#)

*CONFINEMENT REASON

[\[47-C\]](#)

*PRIVATE HEALTH INSURANCE, OR A COMBINATION OF PRIVATE HEALTH INSURANCE AND MEDICAID, IS PAYING OR IS EXPECTED TO PAY MORE THAN 50 PERCENT

YES NO UNKNOWN

[\[32-O\]](#)

[v/^] SHOW/HIDE PERSON REMARKS

[\[33-O\]](#)

PERSON REMARKS (PRINTED)

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[34-O\]](#)

[v/^] SHOW/HIDE FILE DOCUMENTATION NOTES

[\[35-O\]](#)

FILE DOCUMENTATION NOTES

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[36-O\]](#)

[CLEAR PAGE/UNDO CHANGES]

H. SCREENSHOT 2: INSTITUTION RESIDENCE - LEVINGS STATE (MEETS LEVINGS REQUIREMENTS IS NO)

Institution Residence

Name	Social Security Number (SSN)	Role
		Claimant

Period Effective Dates: 01/01/2018 - Continuing

Living Arrangements

- Periods
- 01/01/2018 - Continuing
- Residence Address and Jurisdiction
- Institution Residence
- In-Kind Support and Maintenance
- Living Arrangement Change

*** Indicates required information**
Select from favorites or type contact information
[Show favorites](#)

Institution name

*** Address**

Country

*** Street 1** **Street 2** **Street 3** **Street 4**

*** City/Town** *** State/Territory** *** ZIP Code**

Phone
 U.S. International
10 digit Number

Date institution location began 01/01/2018

*** Medicaid, or Medicare Part A with state buy-in, pays more than 50%**
 Yes No Unknown

*** Institution for Supplemental Nutrition Assistance Program (SNAP) purposes**
 Yes No

*** Meets Levings requirements** [Micro Info](#)
 Yes No Decide later

Admission date 01/01/2018 *** Admission date verified**
 Yes No

*** Institution type**
 Public Private Unknown

*** Confinement reason**

[Show person remarks](#)
No remarks

[Show file documentation notes](#)
No notes

[Undo Changes](#)

I. FACSIMILE 3: INSTITUTION RESIDENCE (NON-LEVINGS STATE)

INSTITUTION RESIDENCE

NAME SOCIAL SECURITY NUMBER(SSN) ROLE

SSSSSSSSSSSSSSSSSSSSSS SSSSSSSSSSSSSSSSS SSSSSSSSSSSSSSSSSSSSS SSSS SSS-SS-SSSS SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS

[\[1-D\]](#)

PERIOD EFFECTIVE DATES SS/SS/SSSS – SS/SS/SSSS

*INDICATES REQUIRED INFORMATION

INSTITUTION FAVORITES

SELECT FROM FAVORITES OR TYPE CONTACT INFORMATION

[\[2-O\]](#)

[\[v/^\]](#) SHOW/HIDE FAVORITES

INSTITUTION FAVORITES

[\[3-O\]](#)

[\[4-O\]](#)

[REFRESH]

MANAGE OFFICE LEVEL FAVORITES

[\[5-D\]](#)

[\[6-D\]](#)

[\[7-D\]](#)

[\[8-O\]](#)

INSTITUTION NAME ADDRESS PHONE ACTIONS

SS[VARIABLES]SS SS[VARIABLES]SS SS[VARIABLES]SS [SELECT]

[\[9-M\]](#)

*INSTITUTION NAME

XX [] UNKNOWN

*ADDRESS

[\[10-M\]](#)

*COUNTRY:

--

[\[11-M\]](#)

[\[12-O\]](#)

[\[14-O\]](#)

[\[15-O\]](#)

*STREET 1

STREET 2

STREET 3

STREET 4

PP[MAXIMUM OF 22 CHARACTERS]PP PP[MAXIMUM OF 22 CHARACTERS]PP

PP[MAXIMUM OF 22 CHARACTERS]PP PP[MAXIMUM OF 22 CHARACTERS]PP

[\[16-M\]](#)

[\[17-C\]](#)

[\[18-C\]](#)

[\[19-C\]](#)

*CITY/TOWN:

STATE/TERRITORY

STATE/PROVINCE/REGION

ZIP CODE

[\[20-C\]](#)

[\[21-O\]](#)

POSTAL CODE

UNKNOWN

[\[22-O\]](#)

[\[23-O\]](#)

[\[24-O\]](#)

PHONE:()U.S. ()INTERNATIONALPHONE: PHONE

PHONE

(999)999-9999 (DOMESTIC) 99[MAX 15 CHARACTERS]99
(INTERNATIONAL)

10-DIGIT NUMBER/COUNTRY CODE + NUMBER

[\[25-D\]](#)

DATE INSTITUTIONALIZATION BEGAN SS/SS/SSSS

[\[29-C\]](#)

*INSTITUTION FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
PURPOSES

() YES () NO

[\[40-D\]](#)

[\[41-C\]](#)

ADMISSION DATE SS/SS/SSSS *ADMISSION DATE VERIFIED

[\[42-O\]](#)

() YES () NO

[X] DISCHARGED FROM THE INSTITUTION

[\[43-C\]](#)

[\[44-C\]](#)

*DISCHARGE DATE 99/99/9999 *DISCHARGE DATE VERIFIED

MM/DD/YYYY

() YES () NO

[\[45-C\]](#)

*INSTITUTION TYPE

PUBLIC PRIVATE UNKNOWN

[\[46-C\]](#)

*CONFINEMENT REASON:

--

[\[26-C\]](#)

*MEDICAID, OR MEDICARE PART A WITH STATE BUY-IN, PAYS MORE THAN 50%

YES NO UNKNOWN

[\[47-C\]](#)

*PRIVATE HEALTH INSURANCE, OR A COMBINATION OF PRIVATE HEALTH INSURANCE AND MEDICAID, IS PAYING OR IS EXPECTED TO PAY MORE THAN 50 PERCENT

YES NO UNKNOWN

[\[32-O\]](#)

[v/^] SHOW/HIDE PERSON REMARKS

[\[33-O\]](#)

PERSON REMARKS (PRINTED)

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[34-O\]](#)

[v/^] SHOW/HIDE FILE DOCUMENTATION NOTES

[\[35-O\]](#)

FILE DOCUMENTATION NOTES

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[36-O\]](#)

[CLEAR PAGE/UNDO CHANGES]

J. SCREENSHOT 3: INSTITUTION RESIDENCE (NON-LEVINGS STATE)

Institution Residence

Name	Social Security Number (SSN)	Role
		Caseman

Period Effective Dates: 01/01/2018 - Continuing

Living Arrangements

Periods

01/01/2018 - Continuing

Residence Address and Jurisdiction

Institution Residence

In Kind Support and Maintenance

Living Arrangement Change

* Indicates required information

Select from favorites or type contact information

[Show favorites](#)

* Institution name

AEC Unknown

* Address

* Country

United States or U.S. Territory

* Street 1: 123 Main Street 2: Street 3: Street 4:

* City/Town: Baltimore * State/Territory: Maryland * ZIP Code: 21224

Unknown

Phone

U.S. International

10-digit Number

Date institutionalization began: 01/01/2010

* Institution for Supplemental Nutrition Assistance Program (SNAP) purposes

Yes No

Admission date: 01/01/2010

* Admission date verified

Yes No

Discharged from the institution

* Institution type

Public Private Unknown

* Confinement reason

--

[Show person remarks](#)

No remarks

[Show file documentation notes](#)

No notes

[Undo Changes](#)

K. FACSIMILE 4: INSTITUTION RESIDENCE - SPECIAL 1619/1611 BENEFITS SELECTED

[\[48-C\]](#)

*INSTITUTION TEMPORARY

(X) YES () NO () DECIDE LATER

1619/1611E SPECIAL BENEFITS

INDIVIDUALS WITH EARNINGS AT OR OVER THE SUBSTANTIAL GAINFUL ACTIVITY (SGA) LIMIT WHO BECOME INSTITUTIONALIZED MAY BE ELIGIBLE FOR BENEFIT CONTINUATION FOR UP TO THE FIRST TWO FULL MONTHS OF INSTITUTIONALIZATION

[\[49-C\]](#)

*EARNINGS AT OR OVER THE SUBSTANTIAL GAINFUL ACTIVITY (SGA) LIMIT BUT REMAINS ELIGIBLE FOR SSI PAYMENT OR MEDICAID UNDER SECTION 1619(A) OR (B)

(X) YES () NO () DECIDE LATER

[\[50-C\]](#)

*ELIGIBLE FOR SSI UNDER SECTION 1619(A) OR (B) IN THE MONTH PRIOR TO THE FIRST FULL MONTH OF INSTITUTIONALIZATION

(X) YES () NO () DECIDE LATER

[\[51-C\]](#)

*INSTITUTION PERMITS CLAIMANT TO RETAIN ANY SSI PAYMENT MADE UNDER THIS PROVISION

(X) YES () NO () DECIDE LATER

[\[52-C\]](#)

*ELIGIBLE FOR AND CHOOSES UP TO 2 MONTHS OF BENEFIT CONTINUATION

(X) YES () NO () DECIDE LATER

[\[32-O\]](#)

[v/^] SHOW/HIDE PERSON REMARKS

[\[33-O\]](#)

PERSON REMARKS (PRINTED)

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[34-O\]](#)

[v/^] SHOW/HIDE FILE DOCUMENTATION NOTES

[\[35-O\]](#)

FILE DOCUMENTATION NOTES

XX[MAXIMUM OF 1000 CHARACTERS]XX

[36-O]

[CLEAR PAGE/UNDO CHANGES]

L. SCREENSHOT 4: INSTITUTION RESIDENCE - 1619/1611 BENEFITS

***Institution temporary**
 Yes No Decide later

1619/1611E Special Benefits
Individuals with earnings at or over the substantial gainful activity (SGA) limit who become institutionalized may be eligible for Special Benefits for up to the first two full months of institutionalization.

***Earnings at or over the substantial gainful activity (SGA) limit but remains eligible for SSI payment or Medicaid under section 1619(a) or (b)**
 Yes No Decide later

***Eligible for SSI under section 1619(a) or (b) in the month prior to the first full month of institutionalization**
 Yes No Decide later

***Institution permits claimant to retain any SSI payment made under this provision**
 Yes No Decide later

***Eligible for and chooses up to 2 months of benefit continuation**
 Yes No Decide later

▼ Show person remarks
No remarks

▼ Show file documentation notes
No notes

[Undo Changes](#)

M. FACSIMILE 5: INSTITUTION RESIDENCE - TI BENEFITS SELECTED

[\[48-C\]](#)

*INSTITUTION TEMPORARY

(X) YES () NO () DECIDE LATER

1619/1611E SPECIAL BENEFITS

INDIVIDUALS WITH EARNINGS AT OR OVER THE SUBSTANTIAL GAINFUL ACTIVITY (SGA) LIMIT WHO BECOME INSTITUTIONALIZED MAY BE ELIGIBLE FOR BENEFIT CONTINUATION FOR UP TO THE FIRST TWO FULL MONTHS OF INSTITUTIONALIZATION

[\[49-C\]](#)

*EARNINGS AT OR OVER THE SUBSTANTIAL GAINFUL ACTIVITY (SGA) LIMIT BUT REMAINS ELIGIBLE FOR SSI PAYMENT OR MEDICAID UNDER SECTION 1619(A) OR (B)

(X) YES () NO () DECIDE LATER

[\[50-C\]](#)

*ELIGIBLE FOR SSI UNDER SECTION 1619(A) OR (B) IN THE MONTH PRIOR TO THE FIRST FULL MONTH OF INSTITUTIONALIZATION

(X) YES () NO () DECIDE LATER

[\[51-C\]](#)

*INSTITUTION PERMITS CLAIMANT TO RETAIN ANY SSI PAYMENT MADE UNDER THIS PROVISION

(X) YES () NO () DECIDE LATER

[\[52-C\]](#)

*ELIGIBLE FOR AND CHOOSES UP TO 2 MONTHS OF BENEFIT CONTINUATION

() YES (X) NO () DECIDE LATER

TEMPORARY INSTITUTIONALIZATION BENEFITS

INDIVIDUALS IN A PUBLIC INSTITUTION WHOSE PRIMARY PURPOSE IS MEDICAL OR PSYCHIATRIC CARE OR IN A PUBLIC OR PRIVATE MEDICAID CERTIFIED FACILITY AND WHOSE STAY IS CERTIFIED BY A PHYSICIAN AS NOT LIKELY TO EXCEED 3 MONTHS, MAY BE ELIGIBLE FOR CONTINUING SSI BENEFITS WHEN

RECEIPT OF BENEFITS IS NECESSARY TO MAINTAIN A LIVING ARRANGEMENT TO WHICH THE INDIVIDUAL MAY RETURN

[\[53-C\]](#)

*ELIGIBLE FOR AND CHOOSES UP TO 3 MONTHS OF TEMPORARY INSTITUTIONALIZATION BENEFITS

(X) YES () NO () DECIDE LATER

[\[54-C\]](#)

*CARE TYPE

--

[\[55-C\]](#)

*WHICH MEMBER OF COUPLE

--

[\[56-C\]](#)

*HOME EXPENSE STATEMENT DATE FOR (FIRST NAME + LAST NAME) (SSN)
99/99/9999

[\[57-C\]](#)

MM/DD/YYYY

*PHYSICIAN CERTIFICATION DATE FOR (FIRST NAME + LAST NAME) (SSN)
99/99/9999

[\[58-C\]](#)

MM/DD/YYYY

[] *TEMPORARY INSTITUTIONALIZATION BENEFIT PERIOD ENDED

[\[32-O\]](#)

[v/^] SHOW/HIDE PERSON REMARKS

[\[33-O\]](#)

PERSON REMARKS (PRINTED)

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[34-O\]](#)

[v/^] SHOW/HIDE FILE DOCUMENTATION NOTES

[35-O]

FILE DOCUMENTATION NOTES

XX[MAXIMUM OF 1000 CHARACTERS]XX

[36-O]

[CLEAR PAGE/UNDO CHANGES]

N. SCREENSHOT 5: INSTITUTION RESIDENCE - TI BENEFITS SELECTED

Institution type
 Public Private Unknown

Confinement reason
Medical or psychiatric care

Medicaid, or Medicare Part A with state buy-in, pays more than 50%
 Yes No Unknown

Private health insurance, or a combination of Private health insurance and Medicaid, is paying or is expected to pay more than 50 percent
 Yes No Unknown

Institution temporary
 Yes No Decide later

1619/1611E Special Benefits
Individuals with earnings at or over the substantial gainful activity (SGA) limit who become institutionalized may be eligible for Special Benefits for up to the first two full months of institutionalization.

Earnings at or over the substantial gainful activity (SGA) limit but remains eligible for SSI payment or Medicaid under section 1619(a) or (b)
 Yes No Decide later

Eligible for SSI under section 1619(a) or (b) in the month prior to the first full month of institutionalization
 Yes No Decide later

Institution permits claimant to retain any SSI payment made under this provision
 Yes No Decide later

Eligible for and chooses up to 2 months of benefit continuation
 Yes No Decide later

Temporary institutionalization benefits
Individuals in a public institution whose primary purpose is medical or psychiatric care or in a public or private Medicaid certified facility and whose stay is certified by a physician as not likely to exceed 3 months, may be eligible for continuing SSI benefits when receipt of benefits is necessary to maintain a living arrangement to which the individual may return.

Eligible for and chooses up to 3 months of temporary institutionalization benefits
 Yes No Decide later

Care type
--

Home expense statement date for RAYAN JUNAID MUHAMMAD - 006-90-2508 - Claimant
mm/dd/yyyy

Physician certification date for RAYAN JUNAID MUHAMMAD - 006-90-2508 - Claimant
mm/dd/yyyy

Show person remarks
No remarks

Show file documentation notes
No notes

[Undo Changes](#)

O. FACSIMILE 6: INSTITUTION RESIDENCE - INELIGIBLE FOR TI BENEFITS

[\[48-C\]](#)

*INSTITUTION TEMPORARY

(X) YES () NO () DECIDE LATER

1619/1611E SPECIAL BENEFITS

INDIVIDUALS WITH EARNINGS AT OR OVER THE SUBSTANTIAL GAINFUL ACTIVITY (SGA) LIMIT WHO BECOME INSTITUTIONALIZED MAY BE ELIGIBLE FOR BENEFIT CONTINUATION FOR UP TO THE FIRST TWO FULL MONTHS OF INSTITUTIONALIZATION

[\[49-C\]](#)

*EARNINGS AT OR OVER THE SUBSTANTIAL GAINFUL ACTIVITY (SGA) LIMIT BUT REMAINS ELIGIBLE FOR SSI PAYMENT OR MEDICAID UNDER SECTION 1619(A) OR (B)

(X) YES () NO () DECIDE LATER

[\[50-C\]](#)

*ELIGIBLE FOR SSI UNDER SECTION 1619(A) OR (B) IN THE MONTH PRIOR TO THE FIRST FULL MONTH OF INSTITUTIONALIZATION

(X) YES () NO () DECIDE LATER

[\[51-C\]](#)

*INSTITUTION PERMITS CLAIMANT TO RETAIN ANY SSI PAYMENT MADE UNDER THIS PROVISION

(X) YES () NO () DECIDE LATER

[\[52-C\]](#)

*ELIGIBLE FOR AND CHOOSES UP TO 2 MONTHS OF BENEFIT CONTINUATION

() YES (X) NO () DECIDE LATER

TEMPORARY INSTITUTIONALIZATION BENEFITS

INDIVIDUALS IN A PUBLIC INSTITUTION WHOSE PRIMARY PURPOSE IS MEDICAL OR PSYCHIATRIC CARE OR IN A PUBLIC OR PRIVATE MEDICAID CERTIFIED FACILITY AND WHOSE STAY IS CERTIFIED BY A PHYSICIAN AS NOT LIKELY TO EXCEED 3 MONTHS, MAY BE ELIGIBLE FOR CONTINUING SSI BENEFITS WHEN

RECEIPT OF BENEFITS IS NECESSARY TO MAINTAIN A LIVING ARRANGEMENT TO WHICH THE INDIVIDUAL MAY RETURN

[\[53-C\]](#)

*ELIGIBLE FOR AND CHOOSES UP TO 3 MONTHS OF TEMPORARY INSTITUTIONALIZATION BENEFITS

YES NO DECIDE LATER

[\[59-C\]](#)

[\[60-O\]](#)

TEMPORARY INSTITUTIONALIZATION INELIGIBILITY REASON LIST OF
TEMPORARY INSTITUTIONALIZATION INELIGIBILITY DECISION CODES

- INDIVIDUAL NOT IN A MEDICAL FACILITY
- INDIVIDUAL DOES NOT HAVE HOME EXPENSES THAT MUST CONTINUE TO BE PAID
- PROOF OF HOME EXPENSES NOT RECEIVED(OBSOLETE)
- PROOF OF HOME EXPENSES NOT SUBMITTED BY REQUIRED DATE
- PHYSICIAN EXPECTS INSTITUTIONALIZATION TO LAST OVER 90 DAYS
- PHYSICIAN CERTIFICATION NOT SUBMITTED BY REQUIRED DATE
- PHYSICIAN'S CERTIFICATION NOT PREPARED AND DATED BY REQUIRED DATE (OBSOLETE)
- PHYSICIAN'S CERTIFICATION NOT RECEIVED (OBSOLETE)
- INDIVIDUAL NOT ELIGIBLE FOR SSI PAYMENT IN MONTH PRIOR TO FIRST MONTH OF INSTITUTIONALIZATION
- INDIVIDUAL DOES NOT HAVE HOME EXPENSES THAT MUST CONTINUE TO BE PAID AND PHYSICIAN CERTIFICATION NOT SUBMITTED BY REQUIRED DATE
- PROOF OF HOME EXPENSES NOT RECEIVED AND PHYSICIAN'S CERTIFICATION NOT RECEIVED BY REQUIRED DATE (OBSOLETE)
- PROOF OF HOME EXPENSES NOT SUBMITTED BY REQUIRED DATE AND PHYSICIAN CERTIFICATION NOT SUBMITTED BY REQUIRED DATE
- PHYSICIAN EXPECTS INSTITUTIONALIZATION TO LAST OVER 90 DAYS AND PHYSICIAN CERTIFICATION NOT SUBMITTED BY REQUIRED DATE

() PHYSICIAN'S CERTIFICATION NOT PREPARED AND DATED BY REQUIRED DATE
AND PHYSICIAN'S CERTIFICATION NOT RECEIVED BY REQUIRED DATE
(OBSOLETE)

() INDIVIDUAL NOT ELIGIBLE FOR SSI PAYMENT IN MONTH PRIOR TO FIRST
MONTH OF INSTITUTIONALIZATION, AND PHYSICIAN CERTIFICATION NOT
SUBMITTED BY REQUIRED

() DECIDE LATER

[\[32-O\]](#)

[v/^] SHOW/HIDE PERSON REMARKS

[\[33-O\]](#)

PERSON REMARKS (PRINTED)

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[34-O\]](#)

[v/^] SHOW/HIDE FILE DOCUMENTATION NOTES

[\[35-O\]](#)

FILE DOCUMENTATION NOTES

XX[MAXIMUM OF 1000 CHARACTERS]XX

[\[36-O\]](#)

P. SCREENSHOT 6: INSTITUTION RESIDENCE - INELIGIBLE FOR TI BENEFITS

***Institution temporary**
 Yes No Decide later

1619/1611E Special Benefits
Individuals with earnings at or over the substantial gainful activity (SGA) limit who become institutionalized may be eligible for Special Benefits for up to the first two full months of institutionalization.

***Earnings at or over the substantial gainful activity (SGA) limit but remains eligible for SSI payment or Medicaid under section 1619(a) or (b)**
 Yes No Decide later

***Eligible for SSI under section 1619(a) or (b) in the month prior to the first full month of institutionalization**
 Yes No Decide later

***Institution permits claimant to retain any SSI payment made under this provision**
 Yes No Decide later

***Eligible for and chooses up to 2 months of benefit continuation**
 Yes No Decide later

Temporary Institutionalization Benefits
Individuals in a public institution whose primary purpose is medical or psychiatric care or in a public or private Medicaid certified facility and whose stay is certified by a physician as not likely to exceed 3 months, may be eligible for continuing SSI benefits when receipt of benefits is necessary to maintain a living arrangement to which the individual may return.

***Eligible for and chooses up to 3 months of temporary institutionalization benefits**
 Yes No Decide later

***Temporary institutionalization ineligibility reason** [List of Temporary Institutionalization Ineligibility Reason Codes](#)

<input type="radio"/> Individual not in a medical facility
<input type="radio"/> Individual does not have home expenses that must continue to be paid
<input type="radio"/> Proof of home expenses not submitted by required date
<input type="radio"/> Physician expects institutionalization to last over 90 days
<input type="radio"/> Physician certification not submitted by required date
<input type="radio"/> Individual not eligible for SSI payment in month prior to first month of institutionalization
<input type="radio"/> Individual does not have home expenses that must continue to be paid and physician certification not submitted by required date
<input type="radio"/> Proof of home expenses not submitted by required date and physician certification not submitted by required date
<input type="radio"/> Physician expects institutionalization to last over 90 days and physician certification not submitted by required date
<input type="radio"/> Individual not eligible for SSI payment in month prior to first month of institutionalization, and physician certification not submitted by required date
<input type="radio"/> Decide later

[Show person remarks](#)
No remarks

[Show file documentation notes](#)
No notes

[Undo Changes](#)

Q. HOW YOU GOT THERE

You:

- Selected Residence type = “Institution” on the Residence Address and Jurisdiction page.
 - Entered LINS into the TRANSFER TO field in MSSICS.
 - Selected Institution Residence from the Person Status page.
 - Selected Institution Residence from the left navigation menu.
- Selected [Previous] on the subsequent page in the path.
- Selected [Next] on the prior page in the path.

R. COMMON FIELDS

[1-D]PERIOD EFFECTIVE DATES: SS/SS/SSSS – SS/SS/SSSS

[2-O][V/^] SHOW/HIDE FAVORITES

[3-O]REFRESH

[4-O]MANAGE OFFICE LEVEL FAVORITES

[5-D]INSTITUTION NAME: SS[MAXIMUM OF 40 CHARACTERS]SS

[6-D]ADDRESS: SS[MAX 134 CHARACTERS]SS

[7-D]PHONE: SS[MAXIMUM OF 15 CHARACTERS]SS

[8-O][SELECT]

[21-O]UNKNOWN: []

[22-O]PHONE: ()

[23-O]PHONE: (999)999-9999 (DOMESTIC)

[24-O]PHONE: 99[MAX 15 CHARACTERS]99 (INTERNATIONAL)

[31-O]MORE INFO

[32-O][V/^] SHOW/HIDE PERSON REMARKS

[33-O]PERSON REMARKS (PRINTED): XX[1000 CHARACTERS MAXIMUM]XX

[34-O][V/^] SHOW/HIDE FILE DOCUMENTATION NOTES

[35-O]FILE DOCUMENTATION NOTES: XX[1000 CHARACTERS MAXIMUM]XX

[36-O][CLEAR PAGE/UNDO CHANGES]

S. FIELD DESCRIPTIONS

[9-M] *INSTITUTION NAME: XX[MAXIMUM OF 40 CHARACTERS]XX [] UNKNOWN

Enter the name of the institution where the claimant resides. Select “Unknown” if you are unable to obtain this information when you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you complete the field.

[10-M] *COUNTRY: - -

Select the Country for the institution address. The default is “United States or U.S. Territory”. When Country is “United States or U.S. Territory”, the following Address fields display:

- Street 1.
- Street 2.
- Street 3.
- Street 4.
- City/Town.
- State/Territory.
- ZIP Code.

When you select a Country other than “United States or U.S. Territory”, the following Address fields display:

- Street 1.
- Street 2.
- Street 3.
- Street 4.
- City/Town.
- State/Province/Region.
- Postal Code.

Note:

When you select “Canada” as the Country, Postal Code cannot be blank.

[11-M] *STREET 1: PP[MAXIMUM OF 22 CHARACTERS]PP

Enter the first line of the street address. This field allows letters, numbers, spaces, hyphens, apostrophes and/or forward slashes. Select “Unknown” if you are unable to obtain the Street 1 address information at the time you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field.

The system prefills this field with Street 1 from the Residence Address and Jurisdiction page, Residence address section.

[12-O] STREET 2: PP[MAXIMUM OF 22 CHARACTERS]PP

Enter the second line of the street address. This field allows letters, numbers, spaces, hyphens, apostrophes and/or forward slashes.

When data is available, the system prefills this field with Street 2 from the Residence Address and Jurisdiction page, Residence address section.

[14-O] STREET 3: PP[MAXIMUM OF 22 CHARACTERS]PP

Enter the third line of the street address. This field allows letters, numbers, spaces, hyphens, apostrophes and/or forward slashes.

When data is available, the system prefills this field with Street 3 from the Residence Address and Jurisdiction page, Residence address section.

[15-O] STREET 4: PP[MAXIMUM OF 22 CHARACTERS]PP

Enter the fourth line of the street address. This field allows letters, numbers, spaces, hyphens, apostrophes and/or forward slashes.

When data is available, the system prefills this field with Street 4 from the Residence Address and Jurisdiction page, Residence address section.

[16-M] *CITY/TOWN: PP[MAXIMUM OF 22 CHARACTERS]PP

Enter the City/Town of the address. This field allows letters, spaces and/or hyphens. Select the “Unknown” checkbox if you are unable to obtain the City/Town information at the time you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field.

When data is available, the system prefills this field with City/Town from the Residence Address and Jurisdiction page, Residence address section.

[17-C] *STATE/TERRITORY: - -

Select the State/Territory from the dropdown list. Select the “Unknown” checkbox if you are unable to obtain the State/Territory information at the time you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field.

When data is available, the system prefills this field with State/Territory from the Residence Address and Jurisdiction page, Residence address section.

[18-C] *STATE/PROVINCE/REGION: PP[MAXIMUM OF 22 CHARACTERS]PP

Enter the State/Province/Region for the address. This field displays when Country [X-M] does not equal “United States or U.S. Territory”. This field allows letters, spaces and hyphens.

When data is available, the system prefills this field with State/Province/Region from the Residence Address and Jurisdiction page, Residence address section.

[19-C] *ZIP CODE: PPPPP

Enter the ZIP Code for the address. Select the “Unknown” checkbox if you are unable to obtain the ZIP Code at the time you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field.

When data is available, the system prefills this field with ZIP Code from the Residence Address and Jurisdiction page, Residence address section.

[20-C] *POSTAL CODE: PPPPPPPPPPPPPPP

Enter the Postal Code for the address. This field allows letters, numbers, spaces and hyphens. You must complete this field when Country [X-M] is “Canada”. When Country is “Canada”, this field must contain the following sequence of characters: alpha, numeric, alpha, space, numeric, alpha, numeric, e.g., X9X 9X9.

Select the “Unknown” checkbox if you are unable to obtain Postal Code information for “Canada” at the time you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field.

When data is available, the system prefills this field with Postal Code from the Residence Address and Jurisdiction page, Residence address section.

[25-D] DATE INSTITUTIONALIZATION BEGAN: SS/SS/SSSS

This is the date the claimant first began residing in an institution during a period of institutionalization.

A period of institutionalization may consist of a single living arrangement period or consecutive living arrangement periods where the Residence type is “Institution” on the Residence address and Jurisdiction page.

The system derives the Date institutionalization began from the Residence start date on first the Residence Address and Jurisdiction page where Residence type is “Institution.”

[26-C] *MEDICAID, OR MEDICARE PART A WITH STATE BUY-IN, PAYS MORE THAN 50%: () YES () NO () UNKNOWN

Select “Yes” if Medicaid, or Medicare Part A with state buy-in, is paying or is expected to pay over 50 percent of the cost of care.

Select “No” if Medicaid, or Medicare Part A with state buy-in, is not paying or is not expected to pay over 50 percent of the cost of care.

Select “Unknown” if you are unable to obtain this information when you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field with either “Yes” or “No.”

When the state shown for the institution’s address is a Levings state, this field displays after Date institutionalization began [X-D].

When the state shown for the institution’s address is not a Levings state and Confinement reason [X-C] is “Medical or psychiatric care”, this field displays after Confinement reason.

[27-C] *MONTHLY CHARGE: 9999.99 [] UNKNOWN

Enter the amount the institution charges for the claimant's food, shelter and services each month.

Select “Unknown” if you are unable to obtain this information when you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field with an amount.

This fields displays when the state shown for the institution’s address is a Levings state.

You must complete this field if Medicaid, or Medicare Part A with state buy-in, pays more than 50% [X-C] is "No" and the state shown for the institution’s address is a Levings state.

Note: This is the usual charge if there is a usual charge. If there is no usual charge, then input the amount the institution estimates for the claimant's cost of food, shelter and services each month.

[28-C] *AMOUNT CLAIMANT PAYS: 9999.99 [] UNKNOWN

Enter the amount the claimant pays towards the monthly cost of the claimant's food, shelter and services each month.

Select "Unknown" if you are unable to obtain this information when you are completing the page. Selecting "Unknown" will result in an incomplete page status and will prevent you from closing the event until you update the field with an amount.

This fields displays when the state shown for the institution's address is a Levings state.

You must complete this field if Medicaid, or Medicare Part A with state buy-in, pays more than 50% [X-C] is "No" and the state shown for the institution's address is a Levings state.

[29-C] INSTITUTION FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) PURPOSES: () YES () NO

Select "Yes" if the institution meets the State requirements for food stamp purposes. Otherwise, select "No".

You must complete this field if the state on the Residence Address and Jurisdiction page, Residence Address, is not California.

[30-C] *MEETS LEVINGS REQUIREMENTS: () YES () NO () DECIDE LATER

Select "Yes" if claimant meets the requirement of the Levings Court Decision.

Select "No" if claimant does not meet the requirement of the Levings Court Decision.

Select "Decide later" if you are unable to obtain this information when you are completing the page. Selecting "Decide later" will result in an incomplete page status and will prevent you from closing the event until you update the field with "Yes" or "No".

This fields displays when the state shown for the institution's address is a Levings state.

If Meets Levings requirements is "No", the system requires additional Institution Residence data, beginning with Admission date [X-C].

[40-D] ADMISSION DATE: SS/SS/SSSS

This is the date the claimant entered this particular institution. The system prefills this with the Residence Start Date from the Residence Address and Jurisdiction page.

[41-C] *ADMISSION DATE VERIFIED: () YES () NO

Select “Yes” if you verified the admission date. Otherwise, select “No”.

Note:

You must verify admission date before adjudication. If you select “No”, the system generates an issue on Development Worksheet (DW01).

[42-O] DISCHARGED FROM THE INSTITUTION:

Select this checkbox when the claimant no longer resides in the institution. When you select the checkbox, the Discharge date [X-C] and Discharge date verified fields [X-C] display.

[43-C] *DISCHARGE DATE: 99/99/9999

Enter the claimant’s discharge date from the institution. “mm/dd/yyyy” displays under the field to indicate the format required.

You must complete this field before you enter a new Admission date or Residence type for a new living arrangement period.

[44-C] *DISCHARGE DATE VERIFIED: YES NO

Select “Yes” if you verified the discharge date. Otherwise, select “No”.

Note: You must verify discharge date. If you select “No”, the system generates an issue on Development Worksheet (DW01).

[45-C] *INSTITUTION TYPE: PUBLIC PRIVATE UNKNOWN

Select “Public” if it is considered a public institution.

Select “Private” if it is considered a private institution.

Select “Unknown” if you are unable to obtain this information when you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field with “Public” or “Private.”

[46-C] *CONFINEMENT REASON: --

Select the reason the claimant is in the institution from the following dropdown list.

- Education or vocational training.
- Medical or psychiatric care.
- Public Emergency Shelter for the Homeless (PESH).
- Publicly Operated Community Residence (POCR).

- Prisoner.
- Other.
- Unknown.

Select “Unknown” if you are unable to obtain this information when you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field with another value from the dropdown list.

[47-C] *PRIVATE HEALTH INSURANCE, OR A COMBINATION OF PRIVATE HEALTH INSURANCE AND MEDICAID, IS PAYING OR IS EXPECTED TO PAY MORE THAN 50 PERCENT: () YES () NO () UNKNOWN

Select “Yes” if private health insurance, or a combination of private health insurance and Medicaid, is paying or is expected to pay more than 50 percent of the cost.

Select “No” if private health insurance, or a combination of private health insurance and Medicaid, is not paying or is not expected to pay more than 50 percent of the cost.

Select “Unknown” if you are unable to obtain this information when you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field with “Yes” or “No.”

This field displays when:

- the Confinement reason [X-C] is “Medical or psychiatric” care, and
- Medicaid, or Medicare Part A with state buy-in, pays more than 50% [X-C] is “No,” and
- the claimant is under age 18 as of the Living Arrangement Start Date, and
- the Residence Start Date is 11/01/1996 or later.

[49-C] *EARNINGS AT OR OVER THE SUBSTANTIAL GAINFUL ACTIVITY (SGA) LIMIT BUT REMAINS ELIGIBLE FOR SSI PAYMENT OR MEDICAID UNDER SECTION 1619(A) OR (B): () YES () NO () DECIDE LATER

Select “Yes” if the claimant has earnings above the substantial gainful activity limit and remains eligible for SSI or Medicaid under 1619(a) or (b).

Select “No” if the claimant does not have earnings above the substantial gainful activity limit, or is not eligible for SSI or Medicaid under 1619(a) or (b).

Select “Decide later” if you are unable to obtain this information when you are completing the page. Selecting “Decide later” will result in an incomplete page status and will prevent you from closing the event until you update the field with “Yes” or “No.”

When you select “No” or “Decide later,” the claimant is not eligible for 2 months of 1619/1611E Special Benefits.

[50-C] *ELIGIBLE FOR SSI UNDER SECTION 1619(A) OR (B) IN THE MONTH PRIOR TO THE FIRST FULL MONTH OF INSTITUTIONALIZATION: () YES () NO () DECIDE LATER

Select “Yes” if the claimant was eligible for SSI under section 1619(a) or (b) in the month prior to the first full month of institutionalization.

Select “No” if the claimant was not eligible for SSI under section 1619(a) or (b) in the month prior to the first full month of institutionalization.

Select “Decide later” if you are unable to obtain this information when you are completing the page. Selecting “Decide later” will result in an incomplete page status and will prevent you from closing the event until you update the field with “Yes” or “No.”

This field displays when Earnings at or over the substantial gainful activity (SGA) limit but remains eligible for SSI payment or Medicaid under section 1619(a) or (b) [X-C] is “Yes.”

When you select “No” or “Decide later,” the claimant is not eligible for 2 months of 1619/1611E Special Benefits.

[51-C] *INSTITUTION PERMITS CLAIMANT TO RETAIN ANY SSI PAYMENT MADE UNDER THIS PROVISION: () YES () NO () DECIDE LATER

Select “Yes” if the institution has agreed to permit the claimant to retain any SSI benefit payment made under this provision.

Select “No” if the institution has not agreed to permit the claimant to retain any SSI benefit payment made under this provision.

Select “Decide later” if you are unable to obtain this information when you are completing the page. Selecting “Decide later” will result in an incomplete page status and will prevent you from closing the event until you update the field with “Yes” or “No.”

This field displays when Eligible for SSI under section 1619(a) or (b) in the month prior to the first full month of institutionalization [X-C] is “Yes.”

When you select “No” or “Decide later,” the claimant is not eligible for 2 months of 1619/1611E Special Benefits.

[52-C] *ELIGIBLE FOR AND CHOOSES UP TO 2 MONTHS OF BENEFIT CONTINUATION: () YES () NO () DECIDE LATER

Select “Yes” if the claimant elects to receive special institution payments under 1619/1611E.

Select “No” if the claimant elects not to receive special institution payments under 1619/1611E.

Select “Decide later” if you are unable to obtain this information when you are completing the page. Selecting “Decide later” will result in an incomplete page status and will prevent you from closing the event until you update the field with “Yes” or “No.”

This field displays when Institution permits claimant to retain any SSI payment made under this provision [X-C] is “Yes.”

When you select “No” or “Decide later,” the claimant is not eligible for 2 months of 1619/1611E Special Benefits.

[53-C] *ELIGIBLE FOR AND CHOOSES UP TO 3 MONTHS OF TEMPORARY INSTITUTIONALIZATION BENEFITS: () YES () NO () DECIDE LATER

Select “Yes” if you determine that the claimant meets the eligibility requirements and the claimant elects to receive temporary institutionalization benefits.

Select “No” if you determine that the claimant does not meet the eligibility requirements or the claimant elects not to receive temporary institutionalization benefits.

Select “Decide later” if you are unable to obtain this information when you are completing the page. Selecting “Decide later” will result in an incomplete page status and will prevent you from closing the event until you update the field with “Yes” or “No.”

This field displays when the claimant is not eligible for or does not choose 2 months of benefit continuation under the 1619/1611E provision, and:

- Medicaid, or Medicare Part A with state buy-in, pays more than 50% [X-C] is “Yes”, or Private health insurance, or a combination of Private health insurance and Medicaid, is paying or is expected to pay more than 50 percent [X-C] is “Yes”, and
- Confinement reason [X-C] is “Medical or psychiatric care,”

or

- Institution type [X-C] is “Public”, and
- Confinement reason is “Medical or psychiatric care.”

Note: If you select “Yes” and the current month is not within the TI period, and the claimant still resides in the institution, you must select “Yes” for Temporary institutionalization benefit period ended [X-C]. This directs the system to default to FLA D or payment status N02 (as appropriate) at the end of the TI period.

Reminder 1: The claimant may choose up to 2 months of benefit continuation or up to 3 months of temporary institutionalization benefits. If the claimant elects 2 months of benefit continuation, he or she may also be eligible for the third month of TI benefits under the temporary institutionalization provision.

Reminder 2: Temporary institutionalization benefits only apply when the claimant would otherwise be in a FLA D or Payment Status N02.

[54-C] *CARE TYPE: --

Select the type of care received from the institution from the following dropdown list:

- Acute care.
- Intermediate care (mental).
- Intermediate care (non-mental).
- Skilled nursing care.
- Unknown.

Select “Unknown” if you are unable to obtain this information when you are completing the page. Selecting “Unknown” will result in an incomplete page status and will prevent you from closing the event until you update the field with another value.

This field displays when Eligible for and chooses up to 3 months of temporary institutionalization benefits [X-C] is “Yes.”

[55-C] *WHICH MEMBER OF COUPLE: --

Select which member of the couple resides in the institution from the following dropdown list:

- (Claimant First Name + Last Name) (Claimant SSN).
- (Claimant Spouse’s First Name + Last Name) (Claimant Spouse’s SSN).
- Both.

This field displays for eligible couples when Eligible for and chooses up to three months of temporary institutionalization benefits [X-C] is “Yes.”

[56-C] *HOME EXPENSE STATEMENT DATE FOR (CLAIMANT FIRST NAME + LAST NAME) (SSN): 99/99/9999

Enter the date you received the home expense statement for the specified individual(s) in the field office. "mm/dd/yyyy" displays under the input field to indicate the required format.

This field displays for the claimant and claimant spouse when Which member of couple [X-C] is “Both.”

You must complete this field when Eligible for and chooses up to 3 months of temporary institutionalization benefits is “Yes,” and

- A Discharge date is present, or
- The TI period ended.

If Eligible for and chooses up to three months of temporary institutionalization benefits [X-C] is “Yes” and this field is blank, an issue is added to the DW01.

[57-C] *PHYSICIAN CERTIFICATION DATE FOR (CLAIMANT FIRST NAME + LAST NAME) (SSN): 99/99/9999

Enter the date you received the physician’s certification for the specified individual(s) in the field office. “mm/dd/yyyy” displays under the input field to indicate the required format.

This field displays for the claimant and claimant spouse when Which member of couple [X-C] is “Both.”

You must complete this field when Eligible for and chooses up to 3 months of temporary institutionalization benefits is “Yes,” and

- A Discharge date is present, or
- The TI period ended.

If Eligible for and chooses up to three months of temporary institutionalization benefits [X-C] is “Yes” and this field is blank, an issue is added to the DW01.

[58-C] *TEMPORARY INSTITUTIONALIZATION BENEFIT PERIOD ENDED: []

Select the checkbox if, as of the current date, the temporary institutionalization period ended. This field notifies the system to build a default of FLA D or payment status N02 (as appropriate) after the TI period.

You must complete this field when Eligible for and chooses up to 3 months of temporary institutionalization benefits is “Yes”, the TI period has ended, and the claimant still resides in the institution.

[59-C] *TEMPORARY INSTITUTIONALIZATION INELIGIBILITY REASON:

- Individual not in a medical facility.
- Individual does not have home expenses that must continue to be paid.
- Proof of home expenses not received (Obsolete).
- Proof of home expenses not submitted by required date.
- Physician expects institutionalization to last over 90 days.
- Physician certification not submitted by required date.
- Physician's certification not prepared and dated by required date (Obsolete).
- Physician's certification not received (Obsolete).
- Individual not eligible for SSI payment in month prior to first month of institutionalization.
- Individual does not have home expenses that must continue to be paid and physician certification not submitted by required date.
- Proof of home expenses not received AND physician's certification not received by required date (Obsolete).
- Proof of home expenses not submitted by required date and physician certification not submitted by required date.
- Physician expects institutionalization to last over 90 days and physician certification not submitted by required date.
- Physician's certification not prepared and dated by required date AND physician's certification not received by required date (Obsolete).
- Individual not eligible for SSI payment in month prior to first month of institutionalization, and physician certification not submitted by required date.
- Decide later.

Select the appropriate reason the claimant is ineligible for TI benefits.

Select "Decide later" if you are unable to obtain this information when you are completing the page. Selecting "Decide later" will result in an incomplete page status and will prevent you from closing the event until you update the field with another value.

You must complete this field when Eligible for and chooses up to 3 months of temporary institutionalization benefits [X-C] is "No," or the Institution type [X-C] is "Public" and the Confinement reason [X-O] is "Prisoner" or "Other."

Reminder: Currently the system cannot send the correct notice to the claimant for an initial claim when a temporary institutionalization ineligibility reason applies. You must enter "Y" in the SUPPRESS SYSTEMS GENERATED NOTICE on Miscellaneous Data (CMSC) and send a manual notice.

[60-O] LIST OF TEMPORARY INSTITUTIONALIZATION INELIGIBILITY DECISION CODES

Select this button to display the list of codes and definition in separate columns that are sortable. The default sort is alphabetical by code.

T. RESULTS

Once all required fields are completed and you select to navigate away from the page, the information entered is saved and you are taken to the page selected.