



Suffolk Independent Living Organization
education - advocacy - empowerment

Joseph M. Delgado
Chief Executive Officer

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Family Memorandum of Understanding and Agreement
“Eligibility and Application Process for Adult Services”

Suffolk Independent Living Organization (SILO) offers a comprehensive and individualized consultant service designed to assist families with developing documentation supporting “Eligibility and Application Process for Adult Services”. Suffolk Independent Living Organization (SILO) will provide the following consultation service for a flat fee payment of \$295.00:

- A comprehensive review of the student’s medical/school records.
- Individualized training specific to understanding the documentation to support the “OPWDD Transmittal for Determination of Developmental Disability”.
- Individualized training specific to develop the documentation supporting the review by the Social Security Administration for Adult/Child Disability.
- Individualized training specific to develop the documentation supporting the application for Supplemental Security Income – SSI with the Social Security Administration.
- Individualized training assisting families with developing “draft” input summarizing information about daily activities identified in a Functional Report – Adult.
- Individualized training assisting families with obtaining input for the “Statement of Claimant or Other Person” form for the review by the Social Security Administration for Adult/Child Disability and the application for Supplemental Security Income – SSI with the Social Security Administration.
- Individualized training specific to benefits for in-school youth and adults referencing the “Social Security Red Book – A Summary Guide to Employment Support For Individuals With Disabilities Under the Social Security Disability Insurance and Supplemental Security Income Programs”.
- Maintain follow-up e-mail and dialogue consultant services at no additional charge.

Additional services available by appointment at SILO: WAIS-IV - \$750.00, ABAS or Vineland-3 – \$250.00, ADOS - Autism Diagnostic Observation Schedule, 2nd edition with CARS - Childhood Autism Rating Scale, 2nd edition in an Autism Specialty Report - \$750.00, CARS – Childhood Autism Rating Scale without ADOS - \$250.00 Social History w/narrative page - \$150.00

Consultant and testing services are scheduled upon receipt of payment. Credit card payments - call Karina Renaldo at SILO 631 880-7929 ext. 128 or mail check payment addressed to “SILO” with this memorandum signed, dated and forwarded to: SILO, 3253 Route 112, Bldg. 10, Medford, NY, 11763 Attn: Karina Renaldo

Signature _____

Date _____

Print Name _____

SILO Chief Executive Officer or Designee Signature _____ Date _____

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)

Note: Social Security Administration staff or others who help people apply for SSI will fill out this form for you.

**Do Not Write in This Space
 DATE STAMP**

I am/We are applying for Supplemental Security Income and any federally administered state supplementation under Title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under Title XIX of the Social Security Act.

Filing Date (MM/DD/YYYY)

Receipt Protective
 SNAP-SSA/APP SNAP-Referred

Preferred Language
 Written: Spoken:

TYPE OF CLAIM Individual Individual with Ineligible Spouse Couple Child Child with Parents

PART 1 - BASIC ELIGIBILITY - Answer the questions below beginning with the first moment of the filing date month.

1.	(a) First Name, Middle Initial, Last Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (MM/DD/YYYY)	Social Security Number
	(b) Did you ever use any other names (including maiden name) or any other Social Security Numbers?	<input type="checkbox"/> YES Go to (c) <input type="checkbox"/> NO Go to (d)		
	(c) Other Name(s)	Other Social Security Number(s) used		
	(d) If you are also filing for Social Security Benefits, go to #2; otherwise complete the following:			
	Parent 1's Name(s)	Parent 2's Name(s)		
	Parent 1's Other Name(s) (Including Name at Birth)	Parent 2's Other Name(s) (Including Name at Birth)		
				Go to #2

2.	Applicant's Mailing Address (Number & Street, Apt. No., P.O. Box, Rural Route)		
	City and State (U.S.)/State/Province/Region (Foreign)	ZIP Code/Postal Code	County/Country

3.	Claimant's Residence Address (If different from applicant's mailing address)		
	City and State (U.S.)/State/Province/Region (Foreign)	ZIP Code/Postal Code	County/Country

4.	DIRECT DEPOSIT PAYMENT INFORMATION (FINANCIAL INSTITUTION)			
	Routing Transit Number	Account Number	<input type="checkbox"/> Checking <input type="checkbox"/> Savings	<input type="checkbox"/> Enroll in Direct Express <input type="checkbox"/> Direct Deposit Refused

FUNCTION REPORT - ADULT

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

It is important that you tell us about your activities and abilities.

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 10, and show the number of the question being answered.
- If a specific activity is performed with the help of others, please indicate that.

Function Report - Adult - Form SSA-3373-BK

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 10**

FUNCTION REPORT - ADULT - THIRD PARTY Form SSA-3380-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

HOW TO COMPLETE THIS FORM

The information that you give on this form will be used to make a decision on the disabled person's claim. You can help by completing as much of the form as you can. When a question refers to the "disabled person," it refers to the person who is applying for or receiving disability benefits.

It is important that you tell us what you know about the disabled person's activities and abilities.

DO NOT ASK THE DISABLED PERSON TO GIVE YOU ANSWERS

- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If you need more space to answer any questions, use the "REMARKS" section on Page 10, and show the number of the question being answered.
- If a specific activity is performed with the help of others, please indicate that.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON
COMPLETING THIS FORM ON PAGE 10**

Function Report - Adult - Third Party Form SSA-3380-BK

STATEMENT OF CLAIMANT OR OTHER PERSON

Name of Wage Earner, Self-employed Person, or SSI Claimant	Social Security Number
Name of Person Making Statement (<i>If other than above wage earner, self-employed person, or SSI claimant</i>)	Relationship to Wage Earner, Self-Employed Person, or SSI Claimant

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

DISABILITY REPORT - APPEAL

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

This report is used to update your information for your disability appeal. Completing this report accurately helps us process your claim. Please complete as much of this report as you can.

IF YOU NEED HELP

Please do **not** ask your health care provider to complete this report. You can get help from other people, such as a friend or family member. If you cannot complete this report, a Social Security representative can assist you. If you make an appointment with us, please complete as much of this report as you can and have it with you for your appointment.

HOW TO COMPLETE THIS REPORT

If you have Internet access, you may be able to complete this report online at www.ssa.gov/disability/appeal.

If you complete this report on paper:

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers, including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION**, unless the report indicates otherwise. You can write "don't know," or "none," or "does not apply" if you need to.
- If you need more space to answer any question, please use the **REMARKS** section on the last page, SECTION 10. Include the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any medical records that you have not given to us, send or bring them to our office with this completed report. Please tell us if you want us to return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and this completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

Roomer-Lodger Agreements

Different SSI Payment Rates: The SSI program has different monthly benefit rates for different living arrangements. In New York State, SSI payments are usually based on three rates. For 2022, those rates are:

- ◆ Living alone - \$928 (includes \$87 state supplement)
- ◆ Living with others and paying fair share of household expenses - \$864 (includes \$23 state supplement)
- ◆ Living in the household of another - \$583.67 (includes \$23 state supplement)

A person is considered living alone when he or she has set expenses and is independent of anyone else. A person is living with others when they share expenses, such as food, utilities, rent, or mortgage. SSA usually assumes that people living together share certain costs related to food and shelter.

Persons getting the lowest SSI rate: If a person cannot pay the fair share of household expenses (one-half of expenses in a household of two, one-third of expenses in a household of three, etc.), they cannot be considered "living with others." For example, an SSI recipient whose fair share in a parent's home would be \$1,000 per month could not possibly pay their share of expenses out of an SSI payment. Unless the SSI recipient can establish a separate living unit, he or she would be considered "living in the household of another" and get paid at the lowest SSI rate.

An SSI recipient can obtain the "living alone rate" by working out a business relationship under a roomer-lodger agreement:

- ◆ This is based on the idea that the adult with a disability pays a flat fee amount per month for shelter costs to the homeowner or lessee (i.e., the primary tenant who rents from a landlord).
- ◆ The homeowner/lessee could be the parent, another relative (other than spouse), or a friend.
- ◆ The amount paid is what the homeowner/lessee would charge anyone else for the room and lodging being provided. They do not "share" household costs. The roomer/lodger's name does not appear on any of the household bills (e.g., electric or gas).
- ◆ This type of living arrangement is only possible if the homeowner/lessee is willing to offer this arrangement to the person. There may be financial circumstances, such as income tax considerations, when such an agreement may not be in the homeowner/lessee's financial best interest.

An SSI recipient can change living arrangements at any time. If a person wishes to establish a roomer-lodger status, he or she should submit a statement from the homeowner/lessee to the Social Security Administration stating how much the SSI recipient is charged as a flat fee per month for room and lodging. The SSI program should accept the agreement and adjust the individual's SSI benefit accordingly. The SSI recipient is then entitled to New York's "living alone" status. The monthly SSI payment would then be based on the \$928 living alone rate (minus any countable income).

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Affidavit

In the matter of the application of

SS# _____

For Supplemental Security Income Benefits

.....
State of _____ :
County of _____ : SS
City of _____ :

I, _____ being duly sworn, deposes and says:

1. I reside at _____.
2. I provide room and lodging for my adult disabled _____, _____
(Relationship) (Name of Disabled Adult)
at the above address each month for a flat fee pursuant to an oral business agreement.
3. I charge _____ \$ _____ per month for room and lodging pursuant to
(Name of Disabled Adult)
that oral agreement.
4. I charge the same amount, \$ _____ per month for any nonrelatives who I took in as a
roomer-lodgers under a similar business arrangement.
5. _____ has no equity of property interest in my home.
(Name of Disabled Adult)
6. _____ does not share in the insurance, maintenance, repair, furnishing,
(Name of Disabled Adult)
decorating, utilities, or any other operational cost of my home.
7. _____ does not participate in any decisions regarding home repairs,
(Name of Disabled Adult)
improvements, or other aspects of daily activities.
8. We do not "pool" our funds for any household expenses.
9. _____ does not contribute to, nor does his name appear on any bill as a
(Name of Disabled Adult)
Responsible party for my actual expenses of operating the house on a per expense or pro-rata
basis because he is a roomer-lodger in my home.



RED BOOK

**A SUMMARY GUIDE TO EMPLOYMENT SUPPORTS
FOR PEOPLE WITH DISABILITIES UNDER THE
SOCIAL SECURITY DISABILITY INSURANCE (SSDI) AND
SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAMS**