**STATE OF MICHIGAN**
Department of Health and Human Services
Aging and Adult Services

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

# DHS-390, ADULT SERVICES APPLICATION

(Revised 9-25)

Complete the CLIENT INFORMATION, SECTION 3, and SECTION 4, and sign and date the second page. Return the first and second pages of this Adult Services Application using the enclosed business reply envelope.

Note: If you need help to complete this application, please indicate what kind of help you need.

☐ Bilingual Interpreter ☐ Sign-language interpreter for the deaf
☐ Other (specify)

## SECTION 1 – FOR DEPARTMENTAL USE ONLY

| 1. Case Name | 2. Log Number | 3. Recipient Identification (ID) Number |
|---|---|---|
| 4. County | 5. Date | |
| 6. Worker Name | 7. Worker Phone Number | |

## SECTION 2 – CLIENT INFORMATION

| 8. Full Name of Person Needing or Requesting Services | | | |
|---|---|---|---|
| 9. Date of Birth (MM-DD-YYYY) | 10. Medicaid/Recipient ID | | |
| 11. Street Address | City | State | Zip Code |
| 12. Phone Number | 13. TTY Number (Teletype for the deaf) | 14. Email Address | |

## SECTION 3 – DEPARTMENT PROGRAMS

1. ☐ Home Help
   Services to help pay for someone to assist with personal care and housekeeping.
2. ☐ Adult Community Placement
   Services for adults who can no longer remain in their own homes. Includes help finding an adult foster care home or home for the aged and services for people living in these settings.
3. ☐ Other Services
   Non-payment services to help adults stay safe in their own homes. Services may include information and referral to other community resources.

IF YOU OR SOMEONE YOU KNOW IS IN NEED OF PROTECTIVE SERVICES, CONTACT CENTRALIZED INTAKE FOR ABUSE, NEGLECT OR EXPLOITATION AT 855-444-3911.

## SECTION 4 – CURRENT SITUATION

1. Your status as a recipient
   a. ☐ Medicaid (MA) recipient
   b. ☐ Medicaid application pending
   c. ☐ Supplemental Security Income (SSI) recipient
   d. ☐ MI Choice Waiver recipient
   e. ☐ PACE recipient
   f. ☐ MI Health Link recipient
   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. Living Arrangement (Select all boxes that apply to you and answer related questions)
   a. ☐ Alone
   b. ☐ With spouse (if married answer questions below)
      Is spouse disabled? ☐ Yes ☐ No
      Is spouse working? ☐ Yes ☐ No
      Full name of spouse
   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? ☐ Yes ☐ No
   g. Do you have a guardian? ☐ Yes ☐ No
      Name of guardian
   h. Is a caregiver/provider already identified? ☐ Yes ☐ No

Read the following statement, sign, and date the application.

I wish 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 5 of this application.

| Client Signature<br>X | Date |
| --- | --- |