DHS-390, ADULT SERVICES APPLICATION

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

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)

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 Services
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 a brief description of the services provided by the Department. Check the box or boxes which describe the services you need or problems where you desire help.

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 home or home for the aged and services for people living in these settings.
3. ☐ **Other Services**
   Nonpayment 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 OR NEGLECT AT 855-444-3911.

SECTION B – CURRENT SITUATION: Check all boxes that apply to you.

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 (Check 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 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? ☐ Yes ☐ No
   g. Does the recipient 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 C of this application.

Signature of Client or Authorized Representative Date