**GOVERNMENT OF GUAM**



**DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES**

**(DIPATTAMENT SALUT PUBLEKO YAN SETBISION SUSIAT)**

**DIVISION OF PUBLIC WELFARE \* BUREAU OF ECONOMIC SECURITY**

123 Chalan Kareta, Route 10 \* Mangilao, Guam 96923

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| **STATEMENT OF LIVING ARRANGEMENT** | |
| (If you are living with others, do not have bills, receipts or agreement, you can use this form.)  **Case Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Case Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **(TO BE COMPLETED BY OWNER / LANDLORD / HOUSEMATE)** | |
| The above-named client resides at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ since \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  with the following arrangements for shelter expense and food: | |
| **SHELTER EXPENSE (Check one)**  **Note: If living with others, please attach applicable current bills / receipts.** | |
| Monthly shelter expenses (Indicate below, the amount the client pays for the following expenses)   |  |  |  | | --- | --- | --- | | Rent $\_\_\_\_\_\_\_\_\_\_\_\_\_ | Sewer $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Power $\_\_\_\_\_\_\_\_\_\_\_\_\_ | Trash $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | Water $\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cooking Fuel $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (How often purchased? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |   Monthly flat rate of $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ which includes the following utilities:   |  |  |  |  | | --- | --- | --- | --- | | Power | Sewer | Cooking Fuel | None | | Water | Trash | Telephone |  |   No shelter expenses at this time  Other (Please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **MEAL ARRANGEMENT** | |
| Is the above-named client severely disabled that he / she cannot purchase or prepare his /her meals?  NO, answer Section A only.  YES, answer Section B only and a *Physician’s Certification Form* is needed. | |
| **Section A:** | Does the above-named client purchase and prepare his / her meals separately from the other household members / family?  YES  NO |
| **Section B:** | Does the above-named disabled client have an arrangement to have his / her meals purchased and prepared separately from the other household members / family?  NO  YES. Please provide the following information about the individual that purchases and prepares the meal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name (Please Print) Relationship to Client |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Owner/Landlord/Housemate Name Owner/ Landlord / Housemate Signature  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone Number Date  CONCURRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client’s Name / Signature Date | |