DEPARTMENT OF HUMAN RESOURCES
DIVISION OF SOCIAL SERVICES

NOTICE OF ACTION ON REQUEST FOR STATE MATERNITY HOME FUNDS

Agency	County Number
Caseworker	Telephone Number -
Agency Address	E-Mail Address

Client Last Name	First Name	Middle Initial .	Birth Date

☐ **SMHF Application for maternity care has been approved.** ☐ **SMHF Application for maternity care has been reauthorized.**

Date Received	Date Approved	Date Admitted	Due Date

Anticipated Care Days at $ Cost $	Provider	TANF Eligible?

Monthly Amount of Relative Contribution to Cost	$
Total Amount of Relative Contribution to Cost	$
Monthly Amount of SSI/TANF Contribution	$
Total Amount of SSI/TANF Contribution	$
Total SMHF Not to Exceed	$

☐ **SMHF Application has been returned.**

- ☐ Incomplete financial information
- ☐ Incomplete social information
- ☐ Missing signature(s)
- ☐ Other

☐ **SMHF application has been withdrawn and case closed.**
If future contacts with client suggest reconsideration of this case, please resubmit the application.

☐ **SMHF application has been denied.**

- ☐ Family financial resources seem adequate to meet cost of service
- ☐ Needs can be met without use of SMHF
- ☐ IV-E Eligible
- ☐ Other

If future contacts with client suggest reconsideration of this case, please resubmit the application.

Family Services Coordinator	Date	

cc: Controller's Office
Provider
File
Family Services Coordinator

DSS-6188 (Rev. 06/06)
Family Support & Child Welfare Services