LDSS-5023 (Rev. 9/14)

NYS Office of Temporary & Disability Assistance

Congregate Care Change Report Form

I. Client Identification

Name:	0Male 0Female	Date of Birth: / /
Social Security Number (last four): XXX-XX-	LOSS Case Number (if available):	
New Provider/Name/Address: County:	Former Provider/Name/Address: County:	
Certificate/License/Provider #	Certificate/License/Provider#	

II. Nature of Placement, Transfer or Other Change (Effective Date):

Type of Placement	Type of Care	Federal Living Arrangement	State Living Arrangement
0Move Into 0Moved Out of	Congregate Care Level 1 - Family Care	A	C
0Move Into 0Moved Out of	Congregate Care Level 2 - Residential Care	A	D
0Move Into 0Moved Out of	Congregate Care Level 3 - Enhanced Residential Care	A	E
0Move Into 0Moved Out of	Medical facility	AID	Z
0Move Into 0Moved Out of	Community or Other (please specify, e.g. deceased):		

III. Custody

For children under 18 years old, who has legal Custody?	0Parent/Guardian 0Social Services 0Other (specify)

IV. Income and Resources

Earned income has changed to: $ /mo. effective:	Unearned income has changed to: $ /mo. effective:
Total countable resources equal:$	effective:

[!]

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V. Authorization for Direct Deposit

D As the Designated Representative payee for this resident, I am requesting that his/her SSP benefits be deposited into this account.	Bank Name and Address _____
D I am requesting that my SSP benefits be deposited into this account.	Name on Account: _____
_____ (Resident Signature)	Routing Number ___
	Account Number __
	Type of Account D Checking D Savings

VI. Authorization

Name:	Title:
Signature: Date:	Telephone:
	E-mail:

VII. Forwarding Instructions

SSI State Supplement Program PO Box 1740 Albany, New York 12201 By E-Mail: otda.sm.ssp@otda.ny.gov By Fax: {518} 486-3459	Social Security Administration Field Office locator: https://secure.ssa.gov/ICON/main.jsp

Questions/More Information?
1-855-488-0541
www.otda.ny.gov/programs/ssp