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| **Facility/Provider Name** |  | | Provider Certification # (if known) | |
| **Facility/Provider Address** |  | | | |
| **Name and Phone No. of Person Filling Out Form** | Name | Phone | | Date |

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| --- | --- | --- | --- | --- |
| **Name of SSP Recipient**  **(Last Name, First Name)** | **Last 4**  **of SSN** | **Residence Address** | **Mailing Address**  **(If different than residence)** | **Agency Rep Payee?** |
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Please return this form to: **NYS OTDA State Supplement Program, PO Box 1740, Albany NY 12201**, or through e-mail at **otda.sm.ssp@otda.ny.gov**, or by fax to: 518-486-3459.