REQUEST FOR AGENCY CONFERENCE (NON-EDITS)

NYC Human Resources Administration
Department of Social Services

MAP-3069b 05/01/2014

I. TO BE COMPLETED BY PROVIDER - Must be submitted **within 60 days** of the original eligibility determination. This form may **not** be used to submit information/documentation that was not previously supplied to us. Information/documentation being supplied for the first time must be supplied as part of the Reapplication process.

A. Identifying Information

Provider Name _____ Code_____

Today's Date_____ Original Determination Date _____

Provider Address _____

Telephone Number _____ Fax Number_____

Consumer Name _____

CIN _____ MAP Case # _____

Submitted by _____ _____
(Print Name) (Signature)

B. ❑ Correct/Add the following information :

Name:_____

Address: _____

_____

SSN: _____

DOB: _____

Sex: _____

Telephone Number: _____

Elig. Period:
(From)_____ (To)_____

Excess Income:_____

Other_____

_____

II. TO BE COMPLETED BY THE MEDICAL ASSISTANCE PROGRAM

MAP Receipt Date:_____

Date Assigned:_____

Assigned To: _____

MAP Receipt Date:_____

Date Assigned: _____

Assigned To: _____

Action Taken/Determination:

- ☐ Case record has been updated to reflect the information provided in Section B, above
- ☐ Original determination was correct. No change will be processed to the consumer's eligibility.
- ☐ Consumer has been found to be eligible for: _____ , effective _____
- ☐ Other

Reason/Details: (use reverse side of sheet if addition space is needed)

_____

_____

MAP WORKER SIGNATURE	SECTION/DIVISION	DATE

Reason/Details (continued)

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