

CONSUMER/PROVIDER REQUEST TO CHANGE INFORMATION ON FILE (DOCUMENTATION REQUIRED)



Note: This document is only to be used to correct/change the information listed on this form. To change a consumer's demographic information, staff is directed to [MAP-751k, Consumer/Provider Request to Change Information on File \(No Documentation Required\)](#).

Case Name: _____

Case Number: _____ CIN: _____

Please be advised that an eligibility notice will be sent regarding the change you requested.

CORRECT/CHANGE THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

Close Case Completely

Additional Details: _____

Acceptable Proof

- Signatures of Consumer and/or Representative on this form

Combine Case

Current Case Number: _____ With Case Number: _____

Additional Details: _____

Acceptable Proof

- Signatures of Consumer and/or Representative on this form

MSSI Case Actions

Re- open closed SSI case

Correct SSI Coverage

Activate SSI case

Update/ Change SSI Case

Case Number

Additional Details:

Acceptable Proof

- Documentation from SSA
- DOH-4220, Access NY Application

Change case head

Case Number:

Name of new Case head:

Acceptable Proof

- Birth certificate
- Guardianship papers
- Letter from SSA

Add Individual to Case

Name: _____

Additional Details: _____

Acceptable Proof

- DOH-4220, Access NY Application

Remove Individual from Case

Additional Details: _____

Acceptable Proof

- Signatures of Consumer and/or Representative on this form

Notification of Death

For: _____

Additional Details: _____

Acceptable Proof

- Death Certificate

Change in Immigration Status

From: _____ To: _____

Additional Details: _____

Acceptable Proofs

- I-94 Arrival Departure Record
- I-551 Permanent Resident Card (Green Card)
- I-766 Employment Authorization Card
- I-797 Notice of Action indicating approval or pending application
- Evidence of continuous United States Residence prior to January 1, 1972
- Other authoritative documents that identify a change in immigration status

Upgrade Eligibility to Include Personal Care/Other Community-Based Long-Term Care (CBLTC) Services/Nursing Home (NH) Services

Additional Details: _____

Acceptable Proofs

- Proof of Income
- Proof of Resource (CBLTC: Resource documents for the current month only and NH: Resource documents for the past 60 months and an immediate need for the services)
- DOH-5178A, Access NY Supplement A

Medicare Savings Program Evaluation (MSP)

Additional Details: _____

Acceptable Proofs

- See attached MAP-628j, Medicare Savings Program (MSP) Documentation Guide
- Note:** If the documents on the MAP-628j were already submitted with your Medicaid application, you do not need to submit any additional documents.

Conversion- Medicaid (MA) and Medicare Savings Program (MSP)

- Convert Medicaid to MSP case "Convert MSP to Medicaid"

Case Number: _____

Additional Details: _____

Acceptable Proofs:

- DOH-422, Access NY Application
- DOH-4328 Medicare Savings Program Application

Budgeting Changes

- Disabled Adult Child (DAC) Medicaid Buy-In for Working People with Disabilities (MBI-WPD)
- Modified Adjusted Gross Income (MAGI) Pickle Reduce Spend Down
- Special Housing Standard after Discharged from Nursing Home or Adult Home and Enrolled in Managed Long-Term Care
- Spousal Impoverishment Spousal Refusal Re-budget case

Additional Details: _____

Acceptable Proofs

- See attached MAP-751x Budgeting Change Documentation Guide

Surplus

Retroactive coverage: _____ Provisional coverage: _____

Update/ Correct coverage: _____

Case Number: _____

Additional Details: _____

Acceptable Proofs

- See attached MAP-751x Budgeting Change Documentation Guide

Pooled Trust

Budgeting for New Trust Submission Budget for Increased Deposits

Additional Details: _____

Acceptable Proofs

- Copy of your Pooled Trust Joinder Agreement
- Copy of Power of Attorney (if applicable)
- Proof of Deposit Made
- Social Security Disability Determination or Disability Request (LDSS-486T Medical Report for Determination of Disability, LDSS-1151, Disability Review, MAP-751e, Authorization to Release Medical Information, OCA-960 Authorization for the Disclosure of Individual Health Information HIPAA Release Form)

Add or Remove Third Party Health Insurance

Additional Details: _____

Acceptable Proofs

- MAP-404d, Notice of Health Insurance Confirmation
- MAP-404e, Notice of Removal of Third-Party Health Insurance
- MAP-404g, Request to Remove "Commercial" Third-Party Health Insurance

Coverage

From: _____ To: _____

Additional Details: _____

Acceptable Proofs

- Medical Bills

Incarcerated Case Actions

AC to IC – Suspending a case due to incarceration.

IC to AC – Unsuspending a case due to release from correctional facility.

Change Not Listed on this Form

If a change you are requesting is not listed on this form, supply additional details in the space provided below:

Name (Print)	Signature	Date
Client Representative Name (Print)	Signature	Date

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at **888-692-6116**. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.