CONSUMER/PROVIDER REQUEST TO CHANGE INFORMATION ON FILE

(DOCUMENTATION REQUIRED)

Human Resources Administration
Department of Social Services

MAP-751w (E) 11/25/2024

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

☐ **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 identifies 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.

☐ **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

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

☐ **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.