ALP MEDICAID COVER SHEET

Human Resources Administration
Department of Social Services

HCSP-3026 01/26/2015

Home Care Services Program
Centralized Medicaid Eligibility Unit
785 Atlantic Avenue, 7th Floor
Brooklyn, New York 11238

DATE: _____

ALP FACILITY NAME: _____

CONTACT NAME: _____

TELEPHONE: _____

CONSUMER NAME: _____ CIN: _____

SOCIAL SECURITY #: _____
(Last four digits only)

You MUST indicate a requested action:

ADMISSIONS/DISCHARGES
(Must include form HCSP-3027)

☐ Conversion of active Medicaid case

☐ Discharge Alert – Residents leaving the ALP facility

Date of discharge: _____

New residence address: _____

_____

OTHER ACTIONS

☐ Renewal

☐ Return Deferral

☐ Pooled Trust, Supplemental Needs Trusts, Other Trusts for active cases

☐ Budget review/correction

☐ Demographic changes (Name, DOB, address etc.)

☐ Medicare Savings Program (MSP) transactions