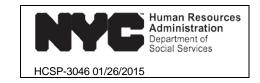
HOME CARE SERVICES PROGRAM COVER SHEET



Home Care Services Program Centralized Medicaid Eligibility Unit 785 Atlantic Avenue, 7 th Floor Brooklyn, New York 11238	DATE:	
CONSUMER NAME:	SOCIAL SECURITY #(Last four digits or	<u></u>
	CIN:(If known)	
NEW MEDICAID AP	PLICATION SUBMISSION	
Please complete all information:		
☐ New Application – DOH-4220 and Sup	oplement A (DOH-4495A)	
NAME OF SUBMITTER:		
ADDRESS:		
TELEPHONE:		
CONTACT NAME:		