HOME CARE SERVICES PROGRAM
COVER SHEET

Human Resources Administration
Department of Social Services
HCSP-3046 01/26/2015

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

DATE: ______________________

CONSUMER NAME: ______________________

SOCIAL SECURITY # ______________
(Last four digits only)

CIN: ______________________
(If known)

NEW MEDICAID APPLICATION SUBMISSION

Please complete all information:

☐ New Application – DOH-4220 and Supplement A (DOH-4495A)

NAME OF SUBMITTER: ______________________

ADDRESS: ______________________

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TELEPHONE: ______________________

CONTACT NAME: ______________________