

### Congregate Care Change Report Form

**I. Client Identification**

Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: MM/DD/YYYY
Social Security Number (last four):  XXX-XX-__-__	LDSS Case Number (if available):	
New Provider/Name/Address:    County:	Former Provider/Name/Address:    County:	
Certificate/License/Provider #	Certificate/License/Provider #	

**II. Nature of Placement, Transfer or Other Change (Effective Date):** \_\_\_\_\_

Type of Placement	Type of Care	Federal Living Arrangement	State Living Arrangement
<input type="checkbox"/> Move Into <input type="checkbox"/> Moved Out of	Congregate Care Level 1 – Family Care	A	C
<input type="checkbox"/> Move Into <input type="checkbox"/> Moved Out of	Congregate Care Level 2 – Residential Care	A	D
<input type="checkbox"/> Move Into <input type="checkbox"/> Moved Out of	Congregate Care Level 3 – Enhanced Residential Care	A	E
<input type="checkbox"/> Move Into <input type="checkbox"/> Moved Out of	Medical facility	A/D	Z
<input type="checkbox"/> Move Into <input type="checkbox"/> Moved Out of	Community or Other (please specify, e.g. deceased):		

**III. Custody**

For children under 18 years old, who has legal Custody?	<input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Social Services <input type="checkbox"/> Other (specify) ____
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**IV. Income and Resources**

Earned income has changed to: \$ _____ /mo. effective: _____	Unearned income has changed to: \$ _____ /mo. effective: _____
Total countable resources equal: \$ _____ effective: _____	

**V. Authorization for Direct Deposit**

<input type="checkbox"/> As the Designated Representative payee for this resident, I am requesting that his/her SSP benefits be deposited into this account.  <input type="checkbox"/> I am requesting that my SSP benefits be deposited into this account.  _____ (Resident Signature)	Bank Name and Address _____ _____ Name on Account _____ Routing Number _____ Account Number _____ Type of Account <input type="checkbox"/> Checking <input type="checkbox"/> Savings
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**VI. Authorization**

Name:	Title:
Signature:	Date:
	Telephone:
	E-mail:

**VII. Forwarding Instructions**

SSI State Supplement Program PO Box 1740 Albany, New York 12201 By E-Mail: <a href="mailto:otda.sm.ssp@otda.ny.gov">otda.sm.ssp@otda.ny.gov</a> By Fax: (518) 486-3459	Social Security Administration Field Office locator:  <a href="https://secure.ssa.gov/ICON/main.jsp">https://secure.ssa.gov/ICON/main.jsp</a>
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Questions/More Information?

1-855-488-0541

[www.otda.ny.gov/programs/ssp](http://www.otda.ny.gov/programs/ssp)