REQUEST TO ASSIGN UNPAID AMOUNTS TO THE NEW YORK STATE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

INDIVIDUAL'S INFORMATION:

LAST NAME	FIRST NAME	MI	TABS ID #

D. O. B.	SOCIAL SECURITY #	DDSO REGION	CURRENT RESIDENCE TYPE

ADDRESS OF RESIDENCE	MAILING ADDRESS (if different)	WILLOWBROOK CLASS MEMBER
		CIRCLE ONE: YES or NO

INDIVIDUAL'S INCOME/ASSETS:

(List any income and/or assets that belong to the individual, even if handled by another person)

TYPE OF INCOME OR ASSET	ACCOUNT NUMBER OR FREQUENCY OF INCOME	AMOUNT	SOURCE / LOCATION

LIABLE PARTY INFORMATION: (if other than service recipient)

LAST NAME	FIRST NAME	RELATIONSHIP	SS # (if known)

ADDRESS	TELEPHONE NUMBERS
	Home:
	Work:
	Cell:

ATTORNEY: (if applicable)

LAST NAME	FIRST NAME	TELEPHONE:

LAW FIRM NAME	ADDRESS:
FAX:	

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WHY ISN'T INDIVIDUAL ELIGIBLE FOR MEDICAID FUNDING*?

_____
_____
_____
_____
_____
_____

COLLECTION ACTIONS TO DATE*:
(Attach copies of all correspondence)

DATE:	ACTION TAKEN:	COMMENTS:

*Please attach notes to this form if there are additional comments or collections activity.

INDIVIDUAL SUBMITTING REQUEST FOR ASSIGNMENT OF UNPAID AMOUNTS:

NAME	TITLE:

AGENCY TELEPHONE #	

SIGNATURE:	DATE:

SECTION BELOW TO BE COMPLETED BY REVENUE SUPPORT FIELD OFFICE:

REQUEST ACCEPTED _____(COMPLETE ATTACHED "ASSIGNMENT TO OPWDD" AND RETURN TO RSFO)

REQUEST DENIED _____

AUTHORIZED BY: _____ DATE: _____

REASON FOR DENIAL: _____

_____

_____

_____