

CENTER/ OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE	SERV. IND	CASE NUMBER	REGISTRY NUMBER	VERS	DISTRICT	SUFFIX	SNAP SUFFIX	CATEGORY	LANG	NUMBER REUSE INDICATOR	
CASE NAME						EFFECTIVE DATE	DISPOSITION <input type="checkbox"/> DENIAL <input type="checkbox"/> REASON CODE <input type="checkbox"/> WITHDRAWAL			SERVICES TRANSACTION TYPE <input type="checkbox"/> NEW OPENING 02 <input type="checkbox"/> REOPEN 10 <input type="checkbox"/> RECERTIFICATION 06					
ELIGIBILITY DETERMINED BY (WORKER):			DATE		ELIGIBILITY APPROVED BY (SUPERVISOR):			DATE		SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION			DATE		
DATE RECEIVED BY AGENCY			EMPLOYED BY: <input type="checkbox"/> SOCIAL SERVICES DISTRICT <input type="checkbox"/> PROVIDER AGENCY SPECIFY: _____												
PA AUTHORIZATION PERIOD				MA AUTHORIZATION PERIOD				SNAP AUTHORIZATION PERIOD				SERVICES AUTHORIZATION PERIOD			
FROM		TO		FROM		TO		FROM		TO		FROM		TO	

NEW YORK STATE APPLICATION FOR CERTAIN BENEFITS AND SERVICES

If you are blind or seriously visually impaired and need this application in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available and how you can request an application in an alternative format, see the instruction book (PUB-1301 Statewide), available at www.otda.ny.gov or <https://www.health.ny.gov/>.

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format? Yes No

If yes, check the type of format you would like: Large Print; Data CD;
 Audio CD; Braille, if you assert that none of the other
 alternative formats will be equally effective for
 you.

If you require another accommodation, please contact your social services district.

We are committed to assisting and supporting you in a professional and respectful manner. You are responsible for participating in activities, including work activities for Public Assistance and the Supplemental Nutrition Assistance Program, where required, so you can become self-sufficient. Whenever you see "Public Assistance" or "PA" on the application, it means "Family Assistance" and/or "Safety Net Assistance." We call both programs "Public Assistance." These PA programs are meant to assist you only until you can fully support yourself and your family. **Please refer to the instruction book (PUB-1301 Statewide) and "What You Should Know" Books 1, 2 and 3 (LDSS-4148A, LDSS-4148B, and LDSS-4148C) when completing this application, and contact your social services district with any questions.**

When you see "MA" on the application, it means "Medicaid." You may apply for MA using this application only if you are also applying for Public Assistance or the Supplemental Nutrition Assistance Program at the same time. If you wish to only apply for MA, you can go online at <https://nystateofhealth.ny.gov/> and/or call 1-855-355-5777 for more information or to apply, or you may use the MA-only paper application - Form DOH-4220, which your worker can give you, or call MA help line at 1-800-541-2831. If you want to apply only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH- 4220 MA application form.