LDSS-3087 (Rev. 6/10) **NYS OTDA**

APPLICATION/RECERTIFICATION
GUIDE DOG FOOD PROGRAM

Directions:

1. **PLEASE PRINT CLEARLY AND DO NOT WRITE IN THE SHADED AREAS.**
2. **BE SURE TO SIGN THE FORM.**
3. **RETURN THE FORM TO YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES.**
   The Local Department is listed in the White Pages of your telephone directory, alphabetically, under the name of your County. New York City residents should send application to: Office of Program Support, Attention: Guide Dog Food Program Coordinator, 180 Water Street, 19th Floor, New York, NY 10038. If you need assistance, contact your local Department of Social Services or the NYS Office of Temporary & Disability Assistance - Hotline toll-free at 1-800-342-3009.

CENTER/OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE **18**	CASE NUMBER	REGISTRY NUMBER	VERS.
CASE NAME				DISTRICT		NUMBER REUSE INDICATOR	
NAME	(LAST)		(FIRST)	(M.I.)	SOCIAL SECURITY NUMBER		

PLEASE LIST HERE ANY MAIDEN NAME OR OTHER NAME BY WHICH YOU ARE KNOWN	ONC	NAME	(LAST)	(FIRST)	(M.I.)
	ONC	NAME	(LAST)	(FIRST)	(M.I.)

DATE OF BIRTH:	(MONTH)	(DAY)	(YEAR)		SEX	(M/F)	:	CLIENT ID NUMBER	
ADDRESS:	(STREET)	(CITY)	(COUNTY)	(STATE)	(ZIP CODE):	PHONE NUMBER			

MAILING ADDRESS IF DIFFERENT FROM ABOVE	(STREET)	(CITY)	(COUNTY)	(STATE)	(ZIP CODE)

If you are a blind, deaf or disabled Supplemental Security Income (SSI) recipient, you may be entitled to a $35 monthly food grant for your guide dog. To be eligible you must reside in New York State, have no earned income, and not be self-employed or work for salary or wages. Grant eligibility will be based on your answers to the following:

	YES	NO
1. Are you a resident of New York State?		
2. Are you blind?		
3. Are you deaf?		
4. Are you disabled?		
5. Are you a recipient of Supplemental Security Income (SSI)?		
6. Do you have any earned income, wages or salary from a job or self-employ?		
7. Do you maintain a guide dog?		

AFFIMATION: I swear (affirm) that the information I have given is correct and I consent to an investigation made by the Department of Social Services with regard to this application. Furthermore, I agree to notify the Department of Social Services of any of the following status changes: Loss of Dog; Termination of SSI Benefits; Change of Address; or Returning to Employment.

SIGNATURE OF APPLICANT *(IF APPLICANT USES "X", HAVE WITNESS SIGN BELOW)*	Date
SIGNATURE OF WITNESS	Date
ADDRESS OF WITNESS (STREET) (CITY) (STATE) (ZIP CODE)	

DISPOSITION

☐ OPENING ☐ DENIAL ☐ RECERTIFICATION ☐ REOPENING ☐ WITHDRAWAL *NOTE: For Recertification, Use Transaction Type 05 - Change*	REASON CODE ☐☐☐	EFFECTIVE DATE
ELIGIBILITY DETERMINED BY (WORKER)	DATE	ELIGIBILITY APPROVED BY (SUPR.)	DATE
SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION	DATE	EMPLOYED BY: ☐ PROVIDER AGENCY SPECIFY ______________________ ☐ SOCIAL SERVICE DISTRICT	