Certificate

Interim Assistance Reimbursement (IAR)

XXXXX (County & State) XXXXX (GRC) ADDENDA

Name of Agency:

Grant Reimbursement Code: 33XXX

I certify that the following incumbents of the Agency are authorized to sign documents reporting the receipt and disbursement of Interim Assistance Reimbursement received in accordance with the Supplemental Security Income Agreement between the State of New York and the Commissioner for the Social Security Administration:

Addition:

Name _____

Job Title _____

Name _____

Job Title _____

Name _____

Job Title _____

Agency Identifying Information

GR Code _____

Agency Name _____

Mailing Address _____

_____

_____

City _____

State _____

Zip Code _____

Agency Name in _____
Notices to Claimant

Direct Deposit Information

Direct Deposit Routing Number_____

Direct Deposit Account Type (checking/saving) _____

Direct Deposit Account Number_____

Agency Contact Information

(Only one email address is needed)

Email address _____

Email address 2_____

Email address 3_____

Contact Person's Name _____

Job Title _____

Telephone Number _____

Certifying Official's Signature **Title** **Date**