LDSS-5023 (Rev. 2/15)

NYS Office of Temporary & Disability Assistance

Congregate Care Change Report Form

I. Return Instructions

Please return this completed form to:

By E-mail: otda.sm.ssp@otda.ny.gov
By Fax: (518) 486-3459
Mailing Address: SSI State Supplement Program
PO Box 1740
Albany, New York 12201

II. Client Identification

Name:	Social Security Number (last four): XXX-XXX- Date of Birth: / /
New Residence Address:	
New Mailing Address (If Different than Residence Address):	
New Provider Name and Address: County:	Former Provider Name and Address: County:
Certificate/License/Provider #	Certificate/License/Provider #

III. Nature of Placement, Transfer or Other Change

Type of Placement	Type of Care(Federal/State Living Arrangement)	Effective Date(s) of Change
☐Move Into ☐Moved Out of	Congregate Care Level 1 – Family Care Federal Living Arrangement Code A, State Code C	
☐Move Into ☐Moved Out of	Congregate Care Level 2 – Residential Care Federal Living Arrangement Code A, State Code D	
☐Move Into ☐Moved Out of	Congregate Care Level 3 – Enhanced Residential Care Federal Living Arrangement Code A, State Code E	
☐Move Into ☐Moved Out of	Medical facility Federal Living Arrangement Code A/D, State Code Z	
☐Move Into ☐Moved Out of	Community or Other (please specify, e.g. deceased):	

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IV. Custody

For children under 18 years old, who has legal Custody?	☐ Parent/Guardian ☐ Social Services ☐ Other (specify) _____

V. Income Changes

Type of Income: (e.g. Social Security Retirement, Social Security Disability, Pension, Wages)	Amount:	Date Income Changed:

VI. Resources

Total countable Resources equal: $_____ effective_____

VII. Authorization for Direct Deposit

☐ As the payee* for this resident, I am requesting that his/her SSP benefits be deposited into the bank account listed below. _____ (Payee Signature) *Must be the Representative Payee approved by SSA or the Designated Representative (DR) Payee approved by the SSP. To apply to become the DR Payee please call 1-855-488-0541	☐ I am requesting that my SSP benefits be deposited into the bank account listed below. _____ (Resident Signature)

Bank Name and Address_____

Name on Account: _____

Routing Number_____

Account Number _____

Type of Account ☐ Checking ☐ Savings

VIII. Authorization

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

Have Questions or need More Information?
1-855-488-0541
www.otda.ny.gov/programs/ssp