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

Certificate/License/Provider #



Name:	Social Security Number (last four): XXX-XXX-	Date of Birth / /			
New Residence Address:	I				
New Mailing Address (If Different than Residence Address):					
New Mailing Address (If Different than Reside	ence Address):				
New Mailing Address (If Different than Reside	ence Address):				
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New Mailing Address (If Different than Reside	Former Provider Name and Address:				
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III. Nature of Placement, Transfer or Other Change

Certificate/License/Provider#

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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٧.	Custody		-			
	For children under 18 years old, who has legal Custody?	☐ Parent/Guardian ☐ Social Services ☐ Other (specify)				
/	Income Changes					
	Type of Income: (e.g. Social Security Retirement, Social Security Disability	ty, Pension, Wages)	Amount:	Date Income Changed:		
/l.	Resources					
	Total countable Resources equal: \$	effective				
/II.	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.	I am requesting that my 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	(Resident Signature)				
	Bank Name and Address					
	Name on Account:					
	Routing Number					
	Account Number					
	Type of Account					
/III.	Authorization					
	Name:	Title:				
	Signature: Date:	Telephone:				
		E-mail:				

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