DEMANN POU DETÈMINASYON POU ANDIKAP

NYC Human Resources Administration
Department of Social Services

MAP-3177 (HC) 11/29/2024

Dat la: _____

Non ki nan Dosye a: _____

Nimewo Dosye (si ou konnen li): _____

Si ou resevwa avantaj Administrasyon Sekirite Sosyal pou Andikap (Social Security Administration, SSA), Revni Sekirite Siplemantè (Supplemental Security Income, SSI) oswa Asirans Sekirite Sosyal pou Andikap (Social Security Disability Insurance, SSDI), **pa** soumèt fòmilè sa a.

Prenon: _____ Non Fanmi: _____ Inisyal Dezyèm Prenon: _____

Adrès Postal: _____ Dat nesans _____ Laj: _____

_____

Nimewo Telefòn: _____ Nimewo Sekirite Sosyal **(Sèlman 4 dènye chif yo):** _____

Tanpri tcheke (✓) bwat sa yo

Ap travay	☐ Wi	☐ Non
Pwoblèm pou wè	☐ Wi	☐ Non
Pwoblèm pou tande (TTY)	☐ Wi	☐ Non
Èske A/R bezwen yon egzanpsyon Medicaid	☐ Wi	☐ Non

Si respons la se **wi**,
ki kalite egzanpsyon: _____

Lang li pale: _____ Lang li ekri: _____

Authorized Representative (Person assisting you with the disability determination request):

First Name: _____ Last Name: _____ MI: _____

Mailing Address: _____ Phone Number: _____

_____

Authorized Representative may (check (✓) all that apply):

☐ Apply Renew Medicaid Application ☐ Discuss Medicaid Application/Case ☐ Receive Mail/Correspondence

Siyati Aplikan/Benefisyè a: _____ Dat la: _____

Authorized Representative Signature: _____ Date: _____