CONSUMER/PROVIDER REQUEST TO CHANGE INFORMATION ON FILE
(No Documentation Required)

NYC Human Resources Administration
Department of Social Services

MAP-751k (E) 11/27/2024
Replaces MAP-751, MAP-751a, and MAP-3069b

Case Name: _____

Case Number: _____ CIN: _____

Change is for: _____

A. CORRECT/ADD THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

☐ **Change Name**
From: _____
To: _____

☐ **Add/Correct Social Security Number (SSN)**
From: _____
To: _____

☐ **Correct Date of Birth**
From: _____
To: _____

☐ **Add/Change Phone Number**
From: _____
To: _____

☐ **Correct Gender Information:** Gender Identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.

From: ☐ Male ☐ Female ☐ Non-Binary or Non-Conforming ☐ X ☐ Transgender
☐ Different Identity: (Describe) _____

To: ☐ Male ☐ Female ☐ Non-Binary or Non-Conforming ☐ X ☐ Transgender
☐ Different Identity: (Describe) _____

☐ **Correct Sex:**

From: ☐ Male ☐ Female ☐ X
☐ Different Identity: (Describe) _____

To: ☐ Male ☐ Female ☐ X
☐ Different Identity: (Describe) _____

☐ **Change Residency Address**
From: _____
To: _____

☐ **Change Mailing Address**
From: _____
To: _____

☐ **Add/Change Secondary Mailing Address**
From: _____
To: _____

CORRECT/ADD THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

Language Spoken

☐ **Language Spoken** From: _____ To: _____

Language Read

We have notices available in the following languages:

- English
- French
- Russian
- Albanian
- Spanish
- Haitian Creole
- Simplified Chinese
- Italian
- Arabic
- Korean
- Traditional Chinese
- Yiddish
- Bengali
- Polish
- Urdu

Tell us what language you want your notices sent to you.

☐ **Language Read** From: _____ To: _____

Alternative Format/Visual Impairment

Do you have a visual disability that makes reading notices difficult? We can give you notices in the following formats. Tell us how you want your notices sent to you:

☐ **Large Print** ☐ **Audio CD** ☐ **Data CD** ☐ **Braille**

B. PROVIDER INFORMATION (TO BE COMPLETED BY PROVIDERS ONLY)

Note: This section is not to be used for Home Care Services Program Providers submissions.

Provider Name: _____

Provider Address: _____

Provider Code: _____ Original Determination Date: _____

Admission Date: _____ Admission Number: _____ Discharge Date: _____

Phone Number: _____ Fax Number: _____

NAME (PRINT)	SIGNATURE	DATE

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at **888-692-6116**. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.