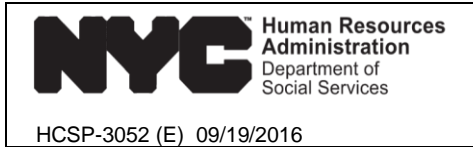


IMMEDIATE NEED TRANSMITTAL TO THE HOME CARE SERVICES PROGRAM



DATE: _____ CONSUMER'S NAME: _____ LAST 4 DIGITS OF CONSUMER'S SSN: _____

From
NAME OF SUBMITTING ORGANIZATION
STREET ADDRESS
CITY, STATE, ZIP CODE

To:
HOME CARE SERVICES PROGRAM – IMMEDIATE NEEDS
785 ATLANTIC AVENUE, 7 th Floor
BROOKLYN, NY 11238

I am submitting this application package on behalf of the above named consumer for processing as an “Immediate Need” for home care services. S/he wishes to be enrolled in the following program (check one):

- Personal Care (PCS) Consumer Directed Personal Assistance (CDPAS)

I understand that the documentation listed in the table(s) below is **required** for this request to be processed. All are attached and appear to be fully completed.

For **all** Immediate Need Requests

OHIP-0103, Attestation of Immediate Need	HCSP M-11q, Medical Request for Home Care	OCA-960, Authorization for Release of Health Information Pursuant to HIPAA
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Also required, in addition to the three items listed above, **if** the consumer already has Medicaid coverage, but it does not include long term care coverage

DOH-4495A, Access NY Supplement A	All necessary proofs that apply to this supplemental form only , as detailed in the DOH-4220 “ Documents Needed When You Apply For Public Health Insurance ” section
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Also, required in addition to everything listed in both tables above, **if** the consumer does not already have Medicaid coverage at all

DOH-4220, Access NY Insurance Application	All necessary proofs as detailed in the DOH-4220 “ Documents Needed When You Apply For Public Health Insurance ” section
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Though not required, I understand that submission of a cover letter that includes an explanation of the immediate need, the status of consumer’s current whereabouts, a listing of submitted documents, the type of service requested (PCS or CDPAS), is strongly recommended.

- I have attached a cover letter I have not submitted a cover letter

Print Name:	Sign Name:	Telephone Number:
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