Attachment II (State Medicaid)

(DRAFT)
LOCAL DISTRICT LETTERHEAD

Date:
Case Number:
Case Name:

(Address of Local Social Security Office)
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Dear Social Security Administration:

Pursuant to New York State law, all applicants must provide or apply for a Social Security Number for receipt of New York State Medical Assistance [18 N.Y.C.R.R. § 360-3.2(j)].

Please assign a Social Security Number to ____
(Immigrant's Name) (Date of Birth) (Sex - M/F)

as the applicant has met all the eligibility requirements for State Medical Assistance, except for the possession of a Social Security Number.

If you have any questions regarding this request, you may contact __________________________________

at ____.

Sincerely,

____
(Name)

____
(Title)