

**NOTIFICATION OF CHANGE (CERTIFICATION PROJECT
NOTIFICACION DE CAMBIO (PROYECTO DE CERTIFICACION)
STATE OF NEW YORK (ESTADO DE NUEVA YORK)
DEPARTMENT OF SOCIAL SERVICES
(DEPARTAMENTO DE SERVICIOS SOCIALES)**

**SOCIAL SERVICES DISTRICT
DISTRITO DE SERVICIOS SOCIAL**

1. **I am notifying you that, as of this date, I am no longer in need of Public Assistance because:
Le notifico que, a partir de esta fecha, ya no necesito Asistencia Publica debido a que:**

2. **I am notifying you that, as of this date, the amount of Public Assistance I need is less than before because:
Le notifico que, a partir de esta fecha, la cantidad de Asistencia Publica que necesito es menos que la de
antes por que:**

3. **I have need for additional Public Assistance because:
Necesito Asistencia Publica adicional debido a que:**

4. **I have moved, my new address is :
Me he mudado, mi direccion nueva es:**

5. **I have no further need for Medicaid/Family Health Plus/Family Planning because:**

**I certify that the above information is a true and correct amendment to my current certification.
Certifico que la informacion arriba indicada es verdadera y correcta enmienda a mi certificacion presente.**

**SIGN YOUR NAME
FIRME AQUI**

**SOCIAL SECURITY NUMBER
NUMERO DE SEGURO SOCIAL**

**DATE
FECHA**

**YOUR CASE NUMBER
EL NUMERO DE SU CASO**