LDSS-4369 (3/09)

BANK INQUIRY AND CLEARANCE REPORT MEDICAID/FAMILY HEALTH PLUS ONLY

Attachment II

TO:	FROM:

On the reverse side of this form we have listed the names, social security numbers and date of birth of individuals applying for or receiving Medicaid/Family Health Plus. When available we have listed account numbers. Please complete and/or provide all information concerning any assets these individuals may have at your institution. **Include information on accounts closed within the last 60 months.**

THE CLIENT HAS GIVEN FULL CONSENT FOR THE RELEASE OF THIS INFORMATION, WHEN APPLYING FOR BENEFITS, PER THE PRIVACY ACT.

This request is made pursuant to Article 1, Section 4 of the N.Y.S. Banking Law and Section 144-a of Social Services Law. This section requires all banking organizations to furnish information to authorized representatives of the local department of social services when the subject of the request is an applicant for or recipient of any assistance, care or services authorized by the Social Services Law.

If you have any questions, please phone the number listed below.

CLIENT'S NAME AND ADDRESS	PREVIOUS ADDRESS

ADDITIONAL INFORMATION

UNIT/WORKER/OFFICE	CASE NUMBER	CASE NAME

SOCIAL SERVICES REPRESENTATIVE SIGNATURE	TITLE	TELEPHONE NO.	DATE SIGNED

COMPLETE REVERSE SIDE

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NAME (Last, First, M.I.)	SOCIAL SECURITY #	DATE OF BIRTH	NO RECORD	ACCOUNT NO.	TYPE	INTEREST RATE	JOINT	DATE OPEN	☐ IF CLOSED LAST W/DRAWAL		BALANCE	
									DATE	AMOUNT	DATE	AMOUNT

Do any of the individuals listed have any of the following? If so, specify owner and nature of accounts.

☐ Bank Loan (Specify): _____

☐ Safe Deposit Box (Specify): _____

☐ Direct Deposit of Payroll/Government Check (Source): _____ (Amount): _____ (Time Period): _____

☐ Other Bank Investment Services (Specify): _____

ADDITIONAL INFORMATION:

BANK ORGANIZATION REPRESENTATIVE SIGNATURE	TITLE	TELEPHONE NO.	DATE SENT
X			

Please Return This Form

THANK YOU FOR YOUR COOPERATON