Department of Social Services
Human Resources Administration
Department of Homeless Services

Family Independence Administration

Request for Identification Card/ Temporary Medicaid Authorization/Update Existing CBIC

Prepare in the following situations:

- Replacement of CBIC or Medicaid card
- Update CBIC
- Undomiciled applicant/participant
- Issuance of Immediate Needs/Expedited Supplemental Nutrition Assistance Program (SNAP) Grant
- Authorized representative (payee) case
- Second Adult in Household Card Request
- Temporary Medicaid Authorization for applicant before case is on WMS

Section I: (To be completed by BOS/Worker)

To: Reception/Disbursement and Collections Unit	From: Benefits Access Center/Supplemental Nutrition Assistance Program (SNAP) Office: Caseload:
Case Name:	Applicant/Participant's Signature: Picture
Authorized Representative (Payee) Name (print):	Authorized Representative (Payee) Signature: Picture
Applicant/Participant CIN:	Applicant/Participant Case Type/Case No./ Registry No./Suffix:

Check Reason for Action:

- ☐ 01 Lost card
- ☐ 02 Stolen
- ☐ 03 Defective
- ☐ 04 Mutilated
- ☐ 06 Surrendered
- ☐ 09 First card/never received
- ☐ CBIC update (no CBIC referral required)

Identification documents witnessed for applicant/participant or authorized representative; the same two pieces must be presented to the Disbursement and Collections (D&C) Unit.

Document	ID Number

Section II: Reason for Request (To be completed by BOS/Worker)

☐ Is the mailing address different than that on WMS?
☐ No ☐ Yes
If yes, complete below.

Care of Name

Street Apt. No.

City State Zip

☐ Mail Permanent Card and Temporary Medicaid Card (**LDSS-4113-2**) (CBIC menu function 1)
☐ Over-the-Counter Permanent Card Request (**LDSS-4113-2**) (CBIC menu function 2)
☐ Vault Card and Mail Card (CBIC Menu Option 1)

☐ Is applicant receiving expedited SNAP benefits and/or an immediate needs grant?
☐ No ☐ Yes
Is the payee correctly established?
☐ No ☐ Yes
If No:
☐ Delete current payee

CIN

☐ Add new payee

CIN

(Turn page)

Section II: Reason for Request (To be completed by BOS/Worker)

☐ Authorized Representative Card (CBIC menu function 3)

Check one: ☐ Agency pickup (at OTC Site) ☐ Mail ☐ Vault Card

Authorized Representative: ____________________ ____ ____________________
First Name M.I. Last Name

☐ Request for Second Adult Card (CBIC menu function 3)

☐ Temporary Medicaid Authorization (**LDSS-2831-A**) **Complete Section IV.**

BOS/Worker's Signature	Date	Supervisor's Signature	Date

Section III: Signature Verification (To be completed by D&C or SNAP Reception)

☐ Vault card (Temporary) issued

☐ Permanent card mail request processed (to be decided by D&C or SNAP Reception) ☐ Pickup CBIC (at OTC Site)

Applicant/Participant's Signature	Date	Authorized Representative (Payee) Signature	Date

Signature(s) verified and documents listed in Section I seen.

SNAP Reception/D&C or Card Producer's Signature: ______________________________ Date:__________

To be Completed by BAC ONLY

Section IV: Additional information for Temporary Medicaid Authorization (**LDSS-4113-2/LDSS-2831A**) (To be completed by BOS/Worker)

Name	Last		First
Address	Street		
	City	State	Zip Code

Enter 7-digit case number and 1-digit suffix ↓

Leave blank ↓

Enter insurance code if available. If not available leave blank. ↓

If enrolled in HIP or HMO plan, enter "P." For all others, enter "A." ↓

Case Number		Category

CIN	Last Name	First Name	Sex	Date of Birth	Ins. Code	Cov. Code	SSN

If temporary Medicaid card (**LDSS-2831A**) is issued, please also give the Applicant/Participant__________________

From ________________