NYS Supplement Program (SSP)
Recovery of Equivalent Benefits (REB) Request Form

I. Client Identification

Name:	County:
Social Security Number (last four): XXX-XX-_ _ _ _	Date of Birth: MM/DD/YYYY
Case Number:	CIN:
Start of REB Retroactive Period: MM/DD/YYYY	End of REB Retroactive Period: MM/DD/YYYY
First Month of Recurring SSP: MM/YYYY	Recurring SSP Benefit Amount:

II. Assistance Provided During REB Period

Month/Year	Amount	Month/Year	Amount

III. Remarks

IV. Authorization - I certify that the above is a true statement of the State/locally funded Assistance provided to this individual during the time period entered above.

Name:	Title:
Signature: Date:	Telephone:
	E-mail: