

# Room of Board Statement

*For use with Medicaid applications*



**Applicant Name**

**Date**

**Case Number**

**Date of Birth**

**Home Address**

**Mailing Address**

**Phone Number**

**Email**

This form is used to verify that the applicant/client resides at the address listed and receives room and board. Complete all applicable fields, including dates of residency and other occupants. Attach a utility bill in the property owner's name, lease agreement, or other proof of residency. Once completed, the form should be signed by the landlord (or property owner) and client, and submitted to the Medicaid office by walk-in, email, or mail, with the required documentation.

## Residency Verification (to be completed by the landlord or homeowner):

I, \_\_\_\_\_, hereby verify that \_\_\_\_\_, is residing in my house/apartment located at \_\_\_\_\_.

Other occupants at this residence are:

1. _____	Relationship: _____
2. _____	Relationship: _____
3. _____	Relationship: _____
4. _____	Relationship: _____
5. _____	Relationship: _____
6. _____	Relationship: _____

Move in Date: \_\_\_\_\_

Move-out Date (if applicable): \_\_\_\_\_

Rent/Board Amount (if applicable): \$ \_\_\_\_\_  
or other \_\_\_\_\_

Weekly

Bi-weekly

Monthly

I,  certify under penalty of perjury that the information I have provided regarding the above-named applicant’s residence is true and correct to the best of my knowledge.

**Landlord/Property Owner Signature**

**Phone Number**

**Email**

**Mailing Address**

**Date**

**Client Perjury Statement:**

Under penalty of perjury, I certify that the information presented in this document is true and accurate to the best of my knowledge. By signing below, I understand that providing false statements may result in termination, denial, or recovery of benefits.

**Client Printed Name**

**Client Signature**

**Date**



**Authorized Representative Name**

**Date**

**Authorized Representative Signature**

**Phone Number**

**Email**

FOR OFFICE USE ONLY

Received by:

Date:

Disclaimer: We do not discriminate on the basis of race, ethnicity, color, national origin, religion, sex, age, or disability. Free language assistance services are available for people whose primary language is not English. We also provide free aids and services to assist with communicating the information effectively (such as interpreters, captioning, Braille, or large print). If you need these services, please contact us by phone or email.

St Thomas/St. John District: 340-774-0930 ext. 4104 or sttjmap@dhs.vi.gov | St. Croix: 340-772-7100 or stxmap@dhs.vi.gov

Privacy Notice: The information provided on this form will be used only for purposes of determining and verifying Medicaid eligibility. Your information is protected under state and federal privacy laws.