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): $ _____ ☐ Weekly ☐ Bi-weekly ☐ Monthly

or other _____

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** _____

OR

Authorized Representative Name _____ **Date** _____

Authorized Representative Signature _____

Phone Number _____ **Email** _____

FOR OFFICE USE ONLY

Received by: _____ Date: _____