# Statement of Circumstances

*For use with Medicaid applications*

| | | | |
|---|---|---|---|
| **Applicant Name** | | **Date** | |
| **Case Number** | | **Date of Birth** | |
| **Home Address** | | | |
| **Mailing Address** | | | |
| **Phone Number** | | **Email** | |

Please use this form to provide additional information, clarification, or explanation related to your Medicaid application.

## Client Prejury 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: