

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:

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.