GOVERNMENT OF THE VIRGIN ISLANDS

Department of Human Services

"Working Together to Make a Difference"

MEDICAL ASSISTANCE PROGRAM

STATEMENT OF FACTS

YOU MUST COMPLETE ALL FIELDS ON THIS APPLICATION TO RECEIVE A TIMELY ELIGIBILITY DETERMINATION

MAP CASE NO:

APPLICANT: _____ MARITAL STATUS: _____ BIRTH DATE: _____ SSN: _____

HOME ADDRESS: _____ MAILING ADDRESS: _____ ☐ Check If No Fixed Address

MOBILE PHONE: ( )_____HOME PHONE: ( )_____WORK PHONE: ( )_____

EMAIL: _____ PREFERRED METHOD OF CONTACT :_____

PREGNANT: ☐ DISABLED: ☐ AGED: ☐ TANF: ☐ FOSTER CARE: ☐ FORMER FOSTER CARE: ☐ EMANCIPATED MINOR: ☐

HOUSEHOLD COMPOSITION

NAME	DATE OF BIRTH	SEX	RACE*	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER	INCOME TYPE (Earnings, Social Security, Unemployment, etc.)	RESOURCE(S) Saving, Checking, Property)	HEALTH INSURANCE PROVIDER

***Race Codes: 1=White or Caucasian, 2=Black or African American, 3=Native Alaskan or American Indian, 11=Asian, 16=Hawaiian, Pacific Islander, 17=Decline to Answer, 18=Other**

I certify through my signature that the answers given are true and correct to the best of my knowledge and belief. I realize that deliberate misrepresentation or concealment of facts may constitute fraud for which I may lose my Medical Assistance coverage or can be prosecuted for a crime.

SIGNATURE OF APPLICANT: _____ DATE: _____