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.

Information provided by you will be disclosed with your application to SGRX, and the selected insurance carrier for the administration of your enrollment and premium payments. You authorize SGRX to access, prepare and submit insurance applications on your behalf, and authorize SGRX to communicate with you via telephone, text message (SMS) and/or e-mail using the contact information you provide to us.

SIGNATURE OF APPLICANT: ______________________________ DATE: ________________________