AFFIDAVIT OF IDENTITY - For Children

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID ELIGIBILITY
SFN 691 (11-2024)

Clear Fields

This form is primarily to be used for children aged 16 or younger. It may be used for children aged 17-18 only as a last resort.

Child's Full Name	Date of Birth	Place of Birth City, State, Country

My relationship to the child(ren) listed above

☐ Parent ☐ Guardian ☐ Caretaker Relative

Full Name (print)

Under penalty of perjury, I certify that I know the identity of the child(ren) listed and that the information I have provided above is true and correct to the best of my knowledge. I understand that state and federal laws provide for fine, imprisonment, or both for any person convicted of providing false information to obtain Medicaid benefits to which he or she is not entitled.

Signature	Date

Submit this form to:

Human Service Zone Office			
Address	City	State	ZIP Code