

Name of Medicaid Applicant/Recipient			
Reason Verification of Citizenship is not S	Supplied		
Under penalty of periury. I certify th	nat 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, imprison	ment, or both for an	
of providing false information to ob	tain Medicaid benefits to which he or she is	s not entitled.	
Signature		Date	
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Submit this form to:			
Human Service Zone Office			
		<u>, </u>	
Address	City	State	ZIP Code