AFFIDAVIT OF IDENTITY - For Children

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 691 (8-2007)

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 aforelisted individual(s)

☐ Parent ☐ Guardian ☐ Caretaker Relative

Full Name (please 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

Return ORIGINAL to:

Social Services Name			
Address	City	State	Zip Code