GOVERNMENT OF THE VIRGIN ISLANDS

Department of Human Services

"Working Together to Make a Difference"

MEDICAL ASSISTANCE PROGRAM

STATEMENT OF FACTS

MAP CASE NO:

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

CHECK IF NO FIXED ADDRESS

HOME ADDRESS: _____ _____ ☐ MAILING ADDRESS: _____

HOME PHONE: ( )_____ WORK PHONE: ( ) _____ MOBILE PHONE: ( ) _____

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

HOUSEHOLD COMPOSITION

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

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 constitue fraud for which I may lose my Medical Assistance coverage or can be prosecuted for a crime.

SIGNATURE OF APPLICANT: _____ DATE: _____