State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
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JON S. CORZINE
Governor

CLARKE BRUNO
Acting Commissioner

ANN CLEMENCY KOHLER
Director

MEDICAID COMMUNICATION NO. 06-12 **DATE:** December 28, 2006

TO: CWA Directors
ISS Area Supervisors
Statewide Eligibility Determination Agency

SUBJECT: Revisions to Medicaid Communication # 06-08
Certification Format for Identity Requirement under the DRA

Attached is the revised certification to be completed by the parent or guardian if they do not have the required identity documents under the DRA for their child(ren) when applying for NJ FamilyCare/Medicaid. To avoid any confusion, please destroy the original "Certification Format for Identity Requirement under the DRA" and replace it with the attached "Certification of Identity".

Questions regarding this communication should be referred to the Office of Policy Development at 609-588-2556.

Sincerely,

Ann Clemency Kohler
Director

ACK:Pp
Attachment

C: Fred M. Jacobs, M.D., J.D., Commissioner
Kathleen M. Mason, Assistant Commissioner
Department of Health and Senior Services

Jeanette Page-Hawkins, Director
Division of Family Development

Greg Fenton, Acting Director
Division of Developmental Disabilities

William Ditto, Director
Division of Disability Services

Kevin Martone, Assistant Commissioner
Division of Mental Health Services

Eileen Crummy, Director
Division of Youth and Family Services

Certification of Identity

I, _____, hereby certify to the following statements:
(name of parent or guardian)

1. I am the parent/guardian of _____

_____.
(names of children as they appear on their birth certificates who are applying for NJ FamilyCare/Medicaid)

2. _____ was born on _____ in _____.
(Name of child #1) *(date of birth)* *(place of birth)*

_____ was born on _____ in _____.
(Name of child #2) *(date of birth)* *(place of birth)*

_____ was born on _____ in _____.
(Name of child #3) *(date of birth)* *(place of birth)*

_____ was born on _____ in _____.
(Name of child #4) *(date of birth)* *(place of birth)*

_____ was born on _____ in _____.
(Name of child #5) *(date of birth)* *(place of birth)*

_____ was born on _____ in _____.
(Name of child #6) *(date of birth)* *(place of birth)*

3. I am applying for NJ FamilyCare/Medicaid coverage for _____

_____.
(child(ren)'s name(s)

4. I have provided accurate information regarding the child(ren) on the application.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willingly false, I am subject to punishment.

_____
Signature of parent or guardian