

DEPARTMENT OF PUBLIC WELFARE  
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

**RECIPIENT STATEMENT FORM**

		<b>1. RECIPIENT S MA NUMBER</b>
2. RECIPIENT'S NAME:		3. BIRTH DATE:
4. RECIPIENT'S ADDRESS:		

**Check one box below:**

5.

I certify that I am the survivor of rape or incest and that I did not report the crime to law enforcement authorities or child protective services.

I certify that I am the survivor of rape or incest and I reported the crime, together with the name of the offender (if known), to:

\_\_\_\_\_

6. DATE OF REPORT (if known):

I understand that any false statements made above are punishable by law and that false reports to law enforcement authorities are punishable by law.

7. \_\_\_\_\_  
SIGNATURE OF PATIENT

8. \_\_\_\_\_  
DATE

**ALL INFORMATION WILL BE KEPT CONFIDENTIAL**