Attachment B

[TO BE PLACED ON LOCAL DISTRICT LETTERHEAD]

REQUEST FOR VERIFICATION OF BIRTH
(LDSS to New York City Department of Health and Mental Hygiene)

NYC Department of Health and Mental Hygiene
Office of Vital Records
125 Worth Street, CN 4, Room 133
New York, NY 10013-4090

DATE:_____

_____
NAME OF APPLICANT

_____
CASE NUMBER (LDSS office use only)

TO WHOM IT MAY CONCERN:

PLEASE PROVIDE BIRTH VERIFICATION THAT A RECORD OF THIS INDIVIDUAL'S BIRTH IS ON FILE TO ALLOW US TO PROVIDE SERVICES FROM THIS AGENCY.

(Name) _____,who states he/she was born

on_____/_____/_____, in _____, New York.

His/her mother's maiden name was: _____

His/her father's name was: _____

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I, _____, understand that this information is being requested and shared for the purpose of determining eligibility for the New York State Medicaid Program, Family Health Plus, Child Health Plus and and the Prenatal Care Assistance Program.

Signature of Client/Authorized Representative: _____

Date _____

PLEASE RETURN THIS FORM AND THE BIRTH VERIFICATION IN THE ENCLOSED POSTAGE-PAID ENVELOPE AND MAIL IT TO THE LOCAL DEPARTMENT SOCIAL SERVICES AT THE ADDRESS INDICATED IN THE BOX BELOW:

WORKER'S NAME	Program/Section	Phone Number