Attachment C

[TO BE PLACED ON LOCAL DISTRICT LETTERHEAD]

REQUEST FOR VERIFICATION OF BIRTH
(New York State LDSS to Out-of-State)
(Request to be used **only** when other state does not have a required form)

Agency_____ DATE:_____

Address_____

_____ _____
NAME OF APPLICANT

State_____ Zip Code_____ _____
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 IN YOUR STATE TO ALLOW US TO PROVIDE SERVICES FROM THIS AGENCY.

(Name) _____,who states he/she was born on_____/_____/_____, in _____, in the State of _____

His/her mother's maiden name was: _____

Her Place of Birth:_____

His/her father's name:_____

His Place of Birth:_____

Information Requested by:_____

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 the Prenatal Care Assistance Program.

Signature of Client/Authorized Representative: _____ Date _____

Relationship to Client:_____

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