State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
QUAKERBRIDGE PLAZA—BUILDING 7 & 5
QUAKERBRIDGE ROAD
TRENTON, NEW JERSEY 08619

ADDRESS REPLY TO:
CN-712
TRENTON, NEW JERSEY 08625

MEDICAID COMMUNICATION NO: 87-11 DATE: April 7, 1987

TO: County Welfare Agency Directors

SUBJECT: Revised PA 1G Certification

Attached is a prototype of the revised PA 1G certification page. The change was necessary to inform clients/applicants that information received from the Internal Revenue Service, the Social Security Administration and the State Unemployment and Wage files will be used in determining Medicaid eligibility.

We would appreciate your using this form in place of the existing certification for all new applicants and all future recertifications.

If you have any questions, contact William Cahill, Office of Eligibility Policy at (609) 588-2556.

Sincerely,

Thomas M. Russo, Director
Division of Medical Assistance
and Health Services

TMR/CPr
Enclosure
c: Odella T. Welch,
Deputy Commissioner

Marion E. Reitz, Acting Director
Division of Public Welfare

Thomas Blatner, Director
Division of Youth and Family Services Management Team

BEFORE YOU SIGN, READ THE STATEMENTS BELOW. IF YOU DO NOT UNDERSTAND OR HAVE ANY QUESTIONS, PLEASE ASK

*I (We) agree that the statements made on this form are true and complete to the best of my (our) knowledge. I (We) know that lying about my (our) situation, failing to give necessary information or causing others to hold back information is against the law and may subject me (us) to prosecution.

*I (We) understand that any information I (We) give is subject to verification by the County Welfare Agency (CWA) and/or other agencies or officers of the Division of Public Welfare (DPW) and the Division of Medical Assistance and Health Services (DMAHS).

*I(We) hereby authorize the County Welfare Agency, Division of Public Welfare, and/or the Division of Medical Assistance and Health Services to contact any individual or other source who may have knowledge about my (our) circumstances (to include IRS, Social Security Wage and Benefit files, State Wage and Unemployment files, and/or credit reporting services), for the sole purpose of verifying the statements I (We) have made.

*I (We) know that any information I (We) give will be used only in connection with my (our) application for public assistance and receipt of Medicaid benefits.

*I (We) understand that Medicaid benefits received after age 65 may be reimburseable to the State of New Jersey from my estate.

*I (We) agree to let the CWA, DPW, and/or the DMAHS know immediately of any change in living arrangements, family situation or money received from any source. If disabled, I (We) agree to report any improvement in my (our) medical condition.

*I (We) understand that as a condition of eligibility for medical assistance, it is deemed that I (We) have assigned to the Commissioner of Human Services, any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party.

*I (We) understand that I (We) may request a fair hearing, if I (We) am (are) not satisfied with any action taken by the CWA, DPW, or DMAHS.

*I (We) understand that I (we) will not be discriminated against because of race, color, religion, sex, handicap, national origin or marital, parental or birth status.

*I (We), by signing below, attest that I (We) have read and agree to these statements and fully realize that the County Welfare Agency and/or the Division of Public Welfare and/or the Division of Medical Assistance and Health Services rely upon the truth and accuracy of my (our) statements.

SIGNATURES

_____ _____
Applicant Date

_____ _____
Spouse Date

_____ _____
Authorized Agent Date

_____
Relationship to Client

Address _____

_____

NOTE: This affidavit must be witnessed by a representative of the County Welfare Agency or the Division of Public Welfare's Institutional Services Section, a duly authorized Notary Public or a person authorized to administer oaths.

SWORN TO AND SUBSCRIBED BEFORE ME)

THIS ____ DAY OF _____ 19___) _____ _____
Witness Title

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES