pennsylvania
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF MEDICAL ASSISTANCE PROGRAMS

RECIPIENT STATEMENT FORM

1. RECIPIENT'S MA NUMBER	

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 are punishable by law.

7. ____
SIGNATURE OF PATIENT

8. ____________________
DATE

ALL INFORMATION WILL BE KEPT CONFIDENTIAL