



# 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**