DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-10161 (07/2018)

STATEMENT OF CITIZENSHIP AND/OR IDENTITY

Complete this form to allow the individual listed below to meet the Medicaid, BadgerCare Plus, and Family Planning Only Services proof of citizenship and identification rule only when no other proof exists or can be shown to prove citizenship or identity.

Complete the appropriate section(s) below and return this form to your local county or tribal agency.

CITIZENSHIP STATEMENT

By completing this section, I attest to the citizenship of the individual named below.

Print Name – Applicant or Member

Date of Birth	Place of Birth (City and State)	Case or Social Security Number

By signing this statement I certify under penalty of perjury and false swearing that the information I have given is correct and complete to the best of my knowledge. I understand that I am only able to do this because I am a U.S. citizen, and I understand that the local agency may contact other persons or organizations to confirm the accuracy of my statement.

Print Name – Person Completing This Form	Relationship to Applicant or Member

SIGNATURE – Person Completing This Form	Date Signed

IDENTITY STATEMENT

By completing this section, I attest to the identity of the individual named below.

Print Name – Applicant or Member	Case or Social Security Number

By signing this statement I certify under penalty of perjury and false swearing that the information I have given is correct and complete to the best of my knowledge. I understand that the local agency may contact other persons or organizations to confirm the accuracy of my statement.

Print Name – Person Completing This Form	Relationship to Applicant or Member

SIGNATURE – Person Completing This Form	Date Signed

RESET FORM