



State of New Jersey

DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES  
P.O. Box 712  
Trenton, NJ 08625-0712  
Telephone 1-800-356-1561

JON S. CORZINE  
Governor

CLARKE BRUNO  
Acting Commissioner

ANN CLEMENCY KOHLER  
Director

MEDICAID COMMUNICATION NO. 06-08

DATE: November 21, 2006

TO: CWA Directors  
ISS Area Supervisors  
Statewide Eligibility Determination Agency

SUBJECT: Revisions to Medicaid Communication # 06-05  
Medicare Beneficiaries Exempt from Citizenship Documentation  
and Certification Format for Identity Requirement Under the  
Deficit Reduction Act (DRA)

As you are aware, the Deficit Reduction Act requires that, as of July 1, 2006, all U.S. citizens and nationals applying for, or renewing, Medicaid coverage to provide documentation of their citizenship status.

Medicaid Communication # 06-05 sets out the groups of individuals who are exempt from this requirement. Please note that in addition to those groups of individuals, **Medicare** beneficiaries are also exempt from the citizenship documentation requirement. Therefore, it is important photocopies of the applicant's Medicare card should be retained in the case record as evidence that additional citizenship documentation is not required.

Also, enclosed is the Certification Format for Identity Requirement under the DRA. This certification needs to be completed by the parent or guardian if they do not have the required identity documents for their child(ren) when applying for Medicaid or NJ FamilyCare.

Should you have any questions, please contact your field representative assigned to your county at 609-588-2556.

Sincerely,

Ann Clemency Kohler  
Director

ACK:p  
Enclosure

C: Fred M. Jacobs, M.D., J.D., Commissioner  
Kathleen M. Mason, Assistant Commissioner  
Department of Health and Senior Services

Jeanette Page-Hawkins, Director  
Division of Family Development

Greg Fenton, Acting Director  
Division of Developmental Disabilities

William Ditto, Director  
Division of Disability Services

Kevin Martone, Assistant Commissioner  
Division of Mental Health Services

Eileen Crummy, Director  
Division of Youth and Family Services



## Certification Format for Identity Requirement under the DRA

### Certification of Identity

I, \_\_\_\_\_, hereby certify to the following statements:  
(name of parent or guardian)

1. I am the parent or guardian of \_\_\_\_\_

\_\_\_\_\_  
(names of children as they appear on their birth certificates)

2. \_\_\_\_\_ was born on \_\_\_\_\_ in \_\_\_\_\_  
(Name of child #1) (date of birth) (place of birth)

\_\_\_\_\_ was born on \_\_\_\_\_ in \_\_\_\_\_  
(Name of child #2) (date of birth) (place of birth)

\_\_\_\_\_ was born on \_\_\_\_\_ in \_\_\_\_\_  
(Name of child #3) (date of birth) (place of birth)

\_\_\_\_\_ was born on \_\_\_\_\_ in \_\_\_\_\_  
(Name of child #4) (date of birth) (place of birth)

\_\_\_\_\_ was born on \_\_\_\_\_ in \_\_\_\_\_  
(Name of child #5) (date of birth) (place of birth)

\_\_\_\_\_ was born on \_\_\_\_\_ in \_\_\_\_\_  
(Name of child #6) (date of birth) (place of birth)

3. I am applying for Medicaid/NJ FamilyCare coverage for \_\_\_\_\_

\_\_\_\_\_  
(child(ren)'s name(s))

4. I have provided accurate information regarding the child(ren) on the  
Medicaid/NJ FamilyCare application.

I certify that the foregoing statements made by me are true. I am aware that if any  
of the foregoing statements made by me are willingly false, I am subject to  
punishment.

\_\_\_\_\_  
Signature of parent or guardian