CERTIFICATION REQUEST

DATE: _____ / _____ / _____ TIME: _____ AM / PM

NAME: _____ , _____ CONTACT NUMBER: _____
LAST: FIRST MI

SOCIAL SECURITY #: _____ - _____ - _____

CASE WORKER: _____ CASE NUMBER: _____

TYPE OF CERTIFICATION

	REASON WHY?
[ ] CHILD SUPPORT	
[ ] GTA	
[ ] GHURA	
[ ] WIC	
[ ] MEDICAID NOT RECEIVED	
[ ] MIP NOT RECEIVED	
[ ] OTHER (SPECIFY)	
[ ] GMHA or MEDICAL PROVIDER: _____ Indicate the Date of Billing: _____ PATIENT NAME: _____	

*** Agency shall be given between 24-48 hours to provide certification form upon request.***

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