## ATTESTATION OF USE OF RECIPIENT FUNDS

NYC Human Resources Administration
Department of Social Services

MAP-3107a (E) 11/18/2024

I, _____, swear or affirm that, the funds used to support any and all
(Your Name)

Surplus Program payments made from my accounts on behalf of _____
(Name of Medicaid Recipient/Surplus Program Applicant)

_____ were provided to me by the above named recipient.
(Case Number)

My relationship to the Medicaid Recipient is _____

In signing this attestation, I certify that the statements above are true, correct, and complete with the full understanding that failing to tell the truth could result in loss of benefits for the above Medicaid recipient.

| | | |
|---|---|---|
| | | |
| (Your Signature) | | (Date) |
| (Your Street Address) | | |
| (Your City, State and Zip Code) | | |
| (Your Telephone Number) | | |

**Do you have a medical or mental health condition or disability?** Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 888-692-6116. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.