



## Strong Families, Strong Futures DC Pregnancy Verification Form

Please print all requested information clearly. Both sections MUST be fully completed and signed. Forms with information missing will be returned for correction, which will delay review of your application.

Completed forms must be uploaded to the Strong Families, Strong Futures DC application portal. Please contact [SFSF@marthastable.org](mailto:SFSF@marthastable.org) if you experience difficulties uploading the verification form.

### **Section 1 - to be completed by applicant: APPLICANT INFORMATION**

First Name:	Last Name:	Middle Name or Initial:
Last 4 of SSN:	Date of Birth:	Phone Number:
Address:		City, State, ZIP:
Email Address:		
Participant Signature: _____		
Date: _____		

### **Section 2 - to be completed by the provider of the service: PREGNANCY CONFIRMATION FORM**

Note to Provider: Your patient is applying for a state funded program that requires validation of pregnancy status. Any information you provide remains confidential between you, the patient, and Martha's Table.

Completion of this form validates that your patient is pregnant and under your care until delivery. I validate that the estimated delivery date of patient is \_\_\_\_\_. As of the date of form completion the patient is \_\_\_\_\_ weeks pregnant.

Name of Medical Facility: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Title: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: (    ) \_\_\_\_\_

Official Stamp Here:

**By signing this form, the undersigned certifies that all information contained herein is true, correct and complete. If at any time it is determined that any information required to be given in this application is inaccurate or incomplete, the undersigned understands that she may lose the benefits of the Strong Families, Strong Futures DC program and may be required to return any and all funds previously received under the Program.**