Maryland
DEPARTMENT OF HEALTH

OFFICE OF CHILDREN AND YOUTH WITH SPECIFIC HEALTH CARE NEEDS
CHILDREN'S MEDICAL SERVICES (CMS) PROGRAM

AFFIDAVIT OF NO INCOME

Applicant's Name: _____
Applicant's SSN or CMS ID#: _____
Applicant's Age:

Name of Person Completing Affidavit: _____
Relationship to Applicant: _____
Today's Date: _____

I _____, swear or affirm that I currently do not have any earned or unearned income of any kind. This includes, but is not limited to, income from wages or self-employment, income from rental property or investments, unemployment, retirement or social security benefits, alimony, or IRA or pension distributions.

I have no income for the following reason(s). Select all that apply:

____ I have no job and have no unemployment benefits.
____ I have lost other sources of income (for example: benefits ended, loss of investment income, loss of alimony payments, etc.).
____ I have a medical condition that prevents me from working.
____ I am receiving financial support from a family member, friend or agency/entity.
____ Other, explained: _____
_____
_____

I SOLEMNLY AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE INFORMATION PROVIDED IN THIS AFFIDAVIT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I understand that if my child is determined eligible for Children's Medical Services, I must report any and all changes (including changes in income, address or household members) within 10 business days to my child's CMS Coordinator or contact a CMS representative at (410) 767-5588.

_____ _____
SIGNATURE (of person completing affidavit) TODAY'S DATE

☐ By checking this box, I certify and affirm that I have answered the questions in this affidavit to the best of my ability.