Maryland
DEPARTMENT OF HEALTH

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

AFFIDAVIT OF SELF-EMPLOYMENT 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 am self-employed.
Name of Business / Type of job: _____ Date Began: _____
If applicable, mark: ____ I am a sub-contractor ____ I own the business ____ I am a partner in a business

Please describe your business or how you earn your income:

_____

_____

_____

I estimate that my earned income will be $ _____ every _____

***Please enclose the most recent year's tax return for your business. ***

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.