OFFICE FOR GENETICS AND PEOPLE WITH SPECIAL HEALTH CARE NEEDS
CHILDREN'S MEDICAL SERVICES (CMS) PROGRAM

AFFIDAVIT OF NO INCOME

APPLICANT'S NAME: ____

Applicant's SSN, Tax ID or CMS ID # (if applicable)**:** ____________________________

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: ____

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

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