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

AFFIDAVIT OF IN-KIND SUPPORT 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 am supporting

______________________________________________________________

I provide the family an amount of $ ___________ every ___________ for personal expenses

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.

___________________________________________________________  DATE

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

___________________________________________________________  DATE

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