**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.

______________________________ ____________________

SIGNATURE (of person completing the 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.

______________________________ ____________________

SIGNATURE (of parent/guardian of the applicant) DATE

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