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

AFFIDAVIT OF RESIDENCY

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 unable to provide an in-state physical address for the purposes of my application for health care coverage because I am currently homeless.

☐ I ______________________________ , do not have the document requested by Children's Medical Services (CMS) to verify my in-state physical address for the following reasons:

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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.