



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

AFFIDAVIT OF SELF-EMPLOYMENT 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 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 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.