Maryland
DEPARTMENT OF HEALTH

OFFICE OF CHILDREN AND YOUTH WITH SPECIFIC HEALTH CARE NEEDS
CHILDREN'S MEDICAL SERVICES (CMS) PROGRAM

AFFIDAVIT OF EMPLOYMENT & INCOME

Applicant's Name: _____
Applicant's SSN or CMS ID#: _____
Applicant's Age:

Name of Person Completing Affidavit: _____
Employer/Business Name: _____
Today's Date: _____

I, _____, swear or affirm that _____ is an employee at _____.

_____ has been working as a _____, since _____.

The employee earns a gross income of $ _____. The frequency of the salary is _____.

If any of this information needs to be verified, you may contact me by telephone at_____ or by email _____.

I SOLEMNLY AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE INFORMATION PROVIDED IN THIS AFFIDAVIT IS TRUE AND COMPLETE TO THE BEST OF MY 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 employer / person completing affidavit) TODAY'S DATE

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

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