OFFICE OF CHILDREN AND YOUTH WITH SPECIFIC HEALTH CARE NEEDS

CHILDREN'S MEDICAL SERVICES (CMS) PROGRAM

AFFIDAVIT OF IN-KIND SUPPORT

Applicant's Name: ____

Applicant's SSN or CMS ID#: ____

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 __________________to cover their 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 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) 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.

____ ________________________

SIGNATURE (of parent/guardian of the applicant) 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.

Rev. 01/24