Maryland
DEPARTMENT OF HEALTH

OFFICE OF CHILDREN AND YOUTH WITH SPECIFIC HEALTH CARE NEEDS

CHILDREN'S MEDICAL SERVICES (CMS) PROGRAM

AFFIDAVIT OF MARYLAND RESIDENCY

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 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 (*indicate the name of the person that you reside with and the address. Must attached proof of address from that person*):

_____

_____

_____

_____

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 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.