## Applicant Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name:** |  |  |  | **Date:** |  |
|  | **Last** | **First** | **M.I.** |  |  |

**Sex:** Female / Male **Ethnicity:** Hispanic or Latino **Race (circle one):** American Indian/Alaska Native, Asian, Black/African American, Middle Eastern, Native Hawaiian/Pacific Islander, White, Other, Prefer not to Say

|  |  |  |
| --- | --- | --- |
| **Address:** |  |  |
|  | **Street Address** | **Apartment/Unit #** |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | **City** | **State** | **ZIP Code** |

|  |
| --- |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary / Alternate |

**SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status: \_\_\_**Single **\_\_\_**Married **\_\_\_\_**Divorce **\_\_\_**Widowed

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are you a citizen of the United States? | YES[ ]  | NO[ ]  | Do you have Medicare? | YES[ ]  | NO[ ]  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is anyone in your household pregnant? | YES[ ]  | NO[ ]  | Expected Due Date? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is anyone in the household disabled? | YES[ ]  | NO[ ]  |  YES NOWas anyone recently released from incarceration? [ ]  [ ]  | NO[ ]  | Has anyone in the household been convicted?  |

## Authorized Representative

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Full Name:** |  |  |  |   |
|  | **Last** | **First** | **M.I.** |  |

|  |  |  |
| --- | --- | --- |
| **Address:** |  |  |
|  | **Street Address** | **Apartment/Unit #** |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | **City** | **State** | **ZIP Code** |

|  |
| --- |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary / Alternate |

**Check what you want the representative to do:**

|  |  |
| --- | --- |
| * Complete Interview for you
 | * Sign your application
 |
| * Receive Notices
 | * Receive your Medical Cards
 |

## Please list all family members in your household: please circle yes if you are applying for that member:

1. **Yes/No – Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN/ITIN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_**

**Sex:** Female / Male **Ethnicity:** Hispanic or Latino **Race (circle one):** American Indian/Alaska Native, Asian, Black/African American, Middle Eastern, Native Hawaiian/Pacific Islander, White, Other, Prefer not to Say

2. **Yes/No – Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN/ITIN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_**

**Sex:** Female / Male **Ethnicity:** Hispanic or Latino **Race (circle one):** American Indian/Alaska Native, Asian, Black/African American, Middle Eastern, Native Hawaiian/Pacific Islander, White, Other, Prefer not to Say

3. **Yes/No – Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN/ITIN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_**

**Sex:** Female / Male **Ethnicity:** Hispanic or Latino **Race (circle one):** American Indian/Alaska Native, Asian, Black/African American, Middle Eastern, Native Hawaiian/Pacific Islander, White, Other, Prefer not to Say

4. **Yes/No – Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN/ITIN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_**

**Sex:** Female / Male **Ethnicity:** Hispanic or Latino **Race (circle one):** American Indian/Alaska Native, Asian, Black/African American, Middle Eastern, Native Hawaiian/Pacific Islander, White, Other, Prefer not to Say

5. **Yes/No – Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN/ITIN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_**

**Sex:** Female / Male **Ethnicity:** Hispanic or Latino **Race (circle one):** American Indian/Alaska Native, Asian, Black/African American, Middle Eastern, Native Hawaiian/Pacific Islander, White, Other, Prefer not to Say

6. **Yes/No – Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN/ITIN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_**

**Sex:** Female / Male **Ethnicity:** Hispanic or Latino **Race (circle one):** American Indian/Alaska Native, Asian, Black/African American, Middle Eastern, Native Hawaiian/Pacific Islander, White, Other, Prefer not to Say

## IMMIGRATION STATUS

**INS Status:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **INS Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**US Entry Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Country of Origin:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Does anyone have unpaid medical bills for the last 3 months and would like to request retro coverage? YES / NO**
* **Does anyone have Private Health Insurance? Yes / No**
* **Does anyone hold Health Insurance in another state? Yes / No**
* **Are you Registered to Vote - Yes/No Would you like to Register to Vote - Yes/No**

## INCOME FROM WORKING

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NAME OF EMPLOYER****(include address & phone number)** | **RATE OF PAY** | **NUMBER OF HRS WORKED** | **AMOUNT PER PAY** | **HOW OFTEN RECEIVED** | **IF JOB ENDED, DATE & AMOUNT OF PAY** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

## OTHER INCOME AND BENEFITS

|  |  |  |
| --- | --- | --- |
| **TYPE OF BENEFIT** | **RECEIVING BENEFITS** | **AMOUNT** |
| * SOCIAL SECURITY
 | YES / NO | $ |
| * SSI
 | YES / NO | $ |
| * SSDI
 | YES / NO | $ |
| * UNEMPLOYMENT
 | YES / NO | $ |
| * PENSION
 | YES / NO | $ |
| * CHILD SUPPORT
 | YES / NO | $ |
| * ALIMONY
 | YES / NO | $ |
| * VA PENSION
 | YES / NO | $ |
| * MILITARY ALLOTMENT
 | YES / NO | $ |
| * MONEY FROM RENTAL INCOME
 | YES / NO | $ |
| * MONEY FROM BABYSITTING
 | YES / NO | $ |
| * CIVIL SERVICE ANNUITY
 | YES / NO | $ |
| * WORKER’S COMPENSATION
 | YES / NO | $ |
| * LUMP SUM AMOUNTS
 | YES / NO | $ |

**Is anyone claiming you on their taxes?** Yes / No

If so, who and their relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Circle Tax Status:** -Head of Household -Married filing jointly -Married filing separately

 -Neither filed/filing taxes -Tax Dependent -Single filing taxes

## SIGNATURE SECTION

I understand that, as required by Maryland law, certain law enforcement agencies that investigate fraud can obtain information about my application, income, benefits, and other documentation as part of their investigation. While access to my application and benefit information is normally limited (under Md. Code Ann. Human Services Article § 1-201), these limits do not apply to these investigative agencies. Such agencies include the Department of Human Services’ Office of the Inspector General. I understand that I do not need to provide consent to these agencies in order for them to investigate any allegations of fraud against me. Any information found as a result of the investigation may be used against me if an allegation of fraud is prosecuted.

I have read or someone has read and explained the entire application to me. I swear of affirm under penalty of perjury, that all the information I gave is true, correct, and complete to the best of my ability, belief and knowledge. I received a copy of my Rights and Responsibilities. I authorize any person, partnership, corporation, association, or governmental agency that knows the facts about my eligibility to give that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has given proof of my eligibility for benefits. I certify, under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. Citizens, lawfully admitted immigrants or individuals in satisfactory immigration status.

|  |  |  |
| --- | --- | --- |
| Signature of Applicant |  | Date |
| Signature of Spouse |  | Date |
| Signature of Authorized Representative |  | Date |

* **I do not wish to apply for Medical Assistance. I withdraw my application.**

**Signature of Applicant/Authorized Representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name of Applicant/Authorized Representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_