

**FACTS ABOUT APPLYING  
FOR  
MEDICAL ASSISTANCE (MA)  
FOR FAMILIES, PREGNANT WOMEN, AND CHILDREN  
&  
MARYLAND CHILDREN'S HEALTH PROGRAM (MCHP)**

**If you would like Temporary Cash Assistance (TCA) or Food Stamps, please contact your local Department of Social Services office (See attached list).**

**Instructions**

- I am a parent or other family member caring for children applying for myself and a child(ren)--*Please complete ALL Sections A-I for MA for Families.*
- I am pregnant and applying only for myself--*Please complete Sections A-H ONLY.*
- I am applying for only a child(ren) (MCHP)--*Please complete Sections A-H ONLY.*

**Social Security Numbers**

- ✧ You must give us a social security number for each person who wants MA/MCHP.
- ✧ If a person who wants MA/MCHP does not have a Social Security Number, that person must apply for a number. We can help you apply.
- ✧ If a person has applied for a Social Security Number, we will not delay the application while waiting for the number.
- ✧ We use Social Security Numbers to prove income. We do not give them to other agencies like Citizenship and Immigration Services.

**Income Information**

- ✧ You may need to give proof of income.
- ✧ The other family members who give us their information will get MA/MCHP if they meet the eligibility guidelines.

**Identity**

- ✧ You must give proof of identity for each person who wants MA/MCHP. See attached citizenship and identity listing on the next page.

**Citizenship and Immigration Status**

- ✧ You must give proof of citizenship or immigration status for each family member who wants MA/MCHP. See attached citizenship and identity listing.

**Emergency Medical Assistance**

- ✧ If you are not a citizen or qualified alien and you are applying only for Emergency MA, you do not need to give a Social Security Number, immigration or citizenship status.

**Application Process**

- ✧ Please complete the application and mail, fax or bring it to your local health department (LHD) or local department of social services (LDSS). Addresses of the LHDs and the LDSSs are located on the last two pages of the application.
- ✧ You can also send your applications electronically through the Service Access & Information Link (SAIL) system at [www.marylandsail.org](http://www.marylandsail.org).

**If you need help applying for benefits, have questions, or do not speak English and need free translation services, please call 1-800-456-8900 or 1-800-332-6347.**

**Si necesita ayuda para Llenar el formulario favor de llamar al 1-800-456-8900 o 1-800-332-6347.**

**website: [www.dhmf.state.md.us](http://www.dhmf.state.md.us)**

## PROCEDURES FOR PROVING CITIZENSHIP AND IDENTITY

For questions regarding citizenship and identity, please call 1-800-492-5231.

A. Use one of the following documents to prove **both** citizenship and identity:

1. U.S. passport (current or expired), or
2. Certificate of Naturalization (N-550 or N-570), or
3. Certificate of Citizenship (N-560 or N-561).

**OR**

B. One document from the Proof of Citizenship list **AND** one document from the Proof of Identity list

Proof of Citizenship	Proof of Identity
<ul style="list-style-type: none"> <li>• U.S. Birth Certificate</li> <li>• Data match of Vital Statistics records by DHMH to document birth record</li> <li>• Systematic Alien Verification for Entitlements (SAVE) - <b>for naturalized citizens only</b></li> <li>• <b>For child under 16:</b> a record created near the date of birth, or 5 years before initial MA/MCHP application, and showing U.S. place of birth on hospital letterhead or other medical record.</li> <li>• Record showing U.S. place of birth, if created at least 5 years before initial MA/MCHP application: record on hospital letterhead or other medical record created near the date of birth, institutional admission papers, signed statement by physician or midwife who attended the birth, Vital Statistics notice of birth registration, insurance record</li> <li>• Final adoption decree for child born in U.S.</li> <li>• Certificate of citizen born abroad (DS-1350, FS-240, FS-545)</li> <li>• Early school record that shows a U.S. place of birth, the date of admission to the school, date of birth (or age at the time the record was made), and the name(s) and place(s) of birth of the applicant's parent(s)</li> <li>• Religious record - recorded in the U.S. within three months of birth showing US birth, and either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization, not the family bible</li> <li>• U.S. military service record showing U.S. place of birth</li> <li>• Evidence of U.S. civil service employment before 6/1/76</li> <li>• Federal or state census record for 1900-1950 showing U.S. citizenship or U.S. place of birth</li> <li>• ID card for naturalized citizen (I-179 or I-197)</li> <li>• <b>Affidavits</b> (can also be used for naturalized citizens) Three written and signed affidavits. Two completed by citizens who have personal knowledge of the person's citizenship, one of whom is not a relative. Both signers must be US citizens. Another affidavit completed by the person, representative, or someone else knowledgeable to explain why the proof isn't available.</li> </ul>	<ul style="list-style-type: none"> <li>• Photo driver's license or Motor Vehicle Administration (MVA) ID card</li> <li>• Data match with other benefit programs (current or past TCA, Food Stamps, TDAP, SSI eligibility) to document identity</li> <li>• Photo school ID card</li> <li>• Photo ID issued by a federal, state, or local government</li> <li>• U.S. military ID card, discharge document, or draft record</li> <li>• Native American Tribal Document</li> <li>• US Coast Guard Merchant Mariner card</li> <li>• For children under 16: Clinic, doctor, hospital, or school record (e.g., DHR/FIA 604 or 604-A form), nursery or day care record including pre-school health forms and Form 1131. School records may include report cards but these records must be verified with the issuing school.</li> <li>• <u>Three or more corroborating documents to prove identity</u> such as marriage licenses, divorce decrees, high school and college diplomas, property deeds/titles, and employer ID cards. This process can be used if they are unable to produce a single, more reliable document such as a driver's license. (These may only be used if the individual did not use affidavits to verify citizenship.)</li> </ul> <p>Note: Recently expired identity documents are usable as long as there is no reason to believe the document does not match the individual.</p> <ul style="list-style-type: none"> <li>• <u>Affidavits can be used for the following</u></li> </ul> <p><u>For Children under 16:</u> written affidavit signed by parent or guardian- but only if an affidavit was not used as proof of citizenship  <u>Disabled individuals (Adult/Child)</u> in long term care or rehabilitative residential care facilities; signed by Facility Director or Administrator.</p>

*Si necesita ayuda para llenar el formulario favor de llamar al 1-800-456-8900*

**MEDICAL ASSISTANCE (MA)/MCHP APPLICATION FOR FAMILIES, PREGNANT WOMEN, AND CHILDREN**

Date Received (Agency use only)

✓ Please PRINT in blue or black ink.

Head of Household Name (Last, First, Middle)		Home Telephone		Work Telephone		Cell Telephone	
Where Do You Live? (Number and Street)		Apt. #	City		State	Zip Code	
Mailing Address (If different from home address)							
<b>What language do you speak?</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <b>Do you have any unpaid medical bills from the past 3 months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what month(s)? _____ <b>Are you or anyone in your household pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, who? _____    Due Date _____ <b>Are you or anyone in your household disabled?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, who? _____    Disability? _____							
Have you ever received assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No				Under what name? _____			

**SECTION A. HOUSEHOLD MEMBERS**

Fill in the blanks for all of the people in your household. Write **YES** for each person you are applying for. Write **NO** for each person you are not applying for.

**Please complete for each person applying for Medical Assistance/MCHP ↓**

APPLYING FOR MEDICAL ASSISTANCE/ MCHP  Y = Yes N = No	NAME (Last, First, Middle)	RELATION TO YOU:	DATE OF BIRTH MM/DD/YY	GENDER M = Male F = Female	MARITAL STATUS  M = Married S = Single D = Divorced P = Separated W = Widowed	*RACE (Indicate below for each person)  A = Asian B = Black/African American C = White N = Amer-Indian or Alaska Native P = Native Hawaiian or Pacific Islander  (You may select more than one code)	*ETHNICITY  H/L = Hispanic/Latino  N/L = Non-Hispanic/Non-Latino	Please complete for each person applying for Medical Assistance/MCHP ↓	
								U.S. CITIZEN  Y = Yes N = No (If No please complete section B)	SOCIAL SECURITY NUMBER (SSN)
<input type="checkbox"/> Y <input type="checkbox"/> N		SELF						<input type="checkbox"/> H/L <input type="checkbox"/> N/L	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N								<input type="checkbox"/> H/L <input type="checkbox"/> N/L	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N								<input type="checkbox"/> H/L <input type="checkbox"/> N/L	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N								<input type="checkbox"/> H/L <input type="checkbox"/> N/L	<input type="checkbox"/> Y <input type="checkbox"/> N

\*You do not have to give information about your race/ethnicity. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter codes for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

—GO TO NEXT PAGE—

You may attach extra pages if you need more space.

**SECTION B. IMMIGRATION STATUS (For Non-Citizens Only)**

Answer these questions for each non-citizen who wants Medical Assistance/MCHP. **IF YOU ARE APPLYING FOR EMERGENCY MEDICAL ASSISTANCE/MCHP, YOU DO NOT HAVE TO FILL IN SECTION B.**

Name (Last, First, Middle)	U.S. Entry Date:	Country of Origin:	Undocumented? <input type="checkbox"/> Yes <input type="checkbox"/> No
	USCIS Number:		
Name (Last, First, Middle)	U.S. Entry Date:	Country of Origin:	Undocumented? <input type="checkbox"/> Yes <input type="checkbox"/> No
	USCIS Number:		
Name (Last, First, Middle)	U.S. Entry Date:	Country of Origin:	Undocumented? <input type="checkbox"/> Yes <input type="checkbox"/> No
	USCIS Number:		

**SECTION C. VOTER REGISTRATION**

If anyone in your household is not registered to vote, would they like to receive voter registration forms?  
 Yes How many? \_\_\_\_\_  No  Already registered

**SECTION D. EARNED INCOME**

Does anyone in your household receive any income from employment?  Yes  No If yes, list all gross income **before taxes** (from full or part-time employment, self-employment, babysitting, odd jobs, day work, roomer/boarder payments, etc.)

NAME (Last, First, Middle)	EMPLOYER (INCLUDE ADDRESS AND PHONE NUMBER)	RATE OF PAY (HOURLY)	NUMBER OF HOURS WORKED	GROSS AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED WE = Weekly BW = Bi-weekly MO = Monthly	JOB START DATE (MM/DD/YY)	JOB END DATE (MM/DD/YY)	STUDENT STATUS (Full or Part-time)

**SECTION E. DEPENDENT CARE**

If anyone in your household pays someone to care for a child or disabled adult in the household, fill in this section:

Name of Care Provider	Telephone	Name of Care Provider	Telephone
Household Member Receiving Care		Household Member Receiving Care	
Who Pays?	Monthly Cost \$	Who Pays?	Monthly Cost \$
Do you have Purchase of Care Services/Vouchers through the Department of Social Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have Purchase of Care Services/Vouchers through the Department of Social Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**SECTION F. CHILD SUPPORT/ALIMONY EXPENSE**

Does any household member pay child support or alimony to a **NON-HOUSEHOLD** member?  Yes  No (Includes current payments, back payments, health insurance)

NAME OF PERSON PAYING	NAME OF PERSON OUTSIDE YOUR HOUSEHOLD WHO IS RECEIVING THESE PAYMENTS	MONTHLY AMOUNT PAID

—GO TO NEXT PAGE—

You may attach extra pages if you need more space.

**SECTION G. UNEARNED AND OTHER INCOME**

List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others, and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

PERSON RECEIVING INCOME	TYPE (For benefits, Include Claimant ID#)	GROSS AMOUNT RECEIVED	HOW MANY TIMES A YEAR?

**NOTE: If you did not list any income in sections D & G, please describe how you get food and shelter?**


**SECTION H. HEALTH INSURANCE**

Does anyone applying have Health Insurance?  Yes  No If yes, is it: (circle one) Private-Payer Employer-Based

**If yes, please answer the following: HEALTH INSURANCE POLICY NUMBER 1**

NAME OF POLICY HOLDER:		INSURANCE COMPANY NAME:	
POLICY NUMBER:	GROUP NUMBER:	EFFECTIVE DATE (MM/DD/YY):	
HOUSEHOLD MEMBER(S) COVERED BY POLICY		RELATIONSHIP OF MEMBER TO POLICY HOLDER	

**If yes, please answer the following: HEALTH INSURANCE POLICY NUMBER 2**

NAME OF POLICY HOLDER:		INSURANCE COMPANY NAME:	
POLICY NUMBER:	GROUP NUMBER:	EFFECTIVE DATE (MM/DD/YY):	
HOUSEHOLD MEMBER(S) COVERED BY POLICY		RELATIONSHIP OF MEMBER TO POLICY HOLDER	

Have you dropped employer-based health insurance coverage for the applicant within 12 months of filing this application?  Yes  No

If yes, please tell us when coverage dropped:  0 – 3 months  4 – 6 months  7 – 9 months  10 – 12 months

If yes, please tell us why coverage was dropped:

<input type="checkbox"/> Moved Out of Service Area of Employer's Health Plans	<input type="checkbox"/> Changed Employer	<input type="checkbox"/> Terminated From Job	<input type="checkbox"/> Employer Dropped Coverage
<input type="checkbox"/> Dropped Limited Benefit Insurance (Vision, Dental, Not Hospital)	<input type="checkbox"/> Quit Job	<input type="checkbox"/> Cost	<input type="checkbox"/> No Longer Needed
		<input type="checkbox"/> COBRA Coverage Ended	<input type="checkbox"/> Other: _____

If a child is not eligible for free medical care, would you (the parent or guardian of the applicant) be willing to pay a premium payment each month to give the child health insurance coverage through MCHP Premium?  Yes  No

**—GO TO NEXT PAGE—**  
**You may attach extra pages if you need more space.**

**Do not complete Section I if you are only applying for your children or are pregnant and only applying for yourself.**

<b>SECTION I. CHILD SUPPORT INFORMATION</b>										
<b>Complete this section if you want MA for a child who has an absent or deceased parent. Fill in a separate section for each absent or deceased parent.</b>										
<b>#1 ABSENT PARENT (AP) INFORMATION</b>										
Name of Absent Parent (Last, First, Middle)				Relationship of absent parent to you			Check one: <input type="checkbox"/> Absent <input type="checkbox"/> Deceased			
CHILD'S NAME		MARITAL STATUS OF CHILD'S PARENTS AT BIRTH								
		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married
		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married
		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married
		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married
		<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated		<input type="checkbox"/> Never Married
Social Security Number (SSN):		Other Name			Date of Birth / /		Age		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
AP's Last Known Address	Number	Street		City		State	Zip Code		Telephone	
AP's Parent's Address	Number	Street		City		State	Zip Code		Telephone	
Driver's License State			Birth Place (City, State)							
<b>Current or Prior Military</b> Dates: From:                      To:			Paying Military Allotment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, To whom?			Military Branch				
Incarcerated <input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never			Institution Name							
<b>ABSENT PARENT INCOME INFORMATION</b>										
Last Known Employer	Name, Address & Telephone									
Second Employer	Name, Address & Telephone									
Other Income/Benefits Received by absent parent:		<input type="checkbox"/> Social Security		<input type="checkbox"/> SSI		<input type="checkbox"/> Veteran's Pension		<input type="checkbox"/> Unemployment		<input type="checkbox"/> Other, list
		<input type="checkbox"/> Worker's Compensation		<input type="checkbox"/> Pension/Retirement		<input type="checkbox"/> Union Benefits				
<b>ABSENT PARENT COURT ORDER INFORMATION</b>										
Paying Support? <input type="checkbox"/> YES <input type="checkbox"/> NO	To Whom?			Last Date Paid			Payment Amount			
Court Ordered? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, where was the court order issued?						Can you give us a copy? <input type="checkbox"/> YES <input type="checkbox"/> NO			

—GO TO NEXT PAGE—  
You may attach extra pages if you need more space.

**Do not complete Section I if you are only applying for your children or are pregnant and only applying for yourself.**

<b>#2 ABSENT PARENT (AP) INFORMATION</b>						
Name of Absent Parent (Last, First, Middle)			Relationship of absent parent to you		Check one: <input type="checkbox"/> Absent <input type="checkbox"/> Deceased	
CHILD'S NAME		MARITAL STATUS OF CHILD'S PARENTS AT BIRTH				
		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Unknown	<input type="checkbox"/> Separated	<input type="checkbox"/> Never Married
		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Unknown	<input type="checkbox"/> Separated	<input type="checkbox"/> Never Married
		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Unknown	<input type="checkbox"/> Separated	<input type="checkbox"/> Never Married
		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Unknown	<input type="checkbox"/> Separated	<input type="checkbox"/> Never Married
		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Unknown	<input type="checkbox"/> Separated	<input type="checkbox"/> Never Married
Social Security Number (SSN):		Other Name		Date of Birth / /	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
AP's Last Known Address	Number	Street	City	State	Zip Code	Telephone
AP's Parent's Address	Number	Street	City	State	Zip Code	Telephone
Driver's License State		Birth Place (City, State)				
<b>Current or Prior Military</b> Dates: From:                      To:		Paying Military Allotment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, To whom?		Military Branch		
Incarcerated <input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never			Institution Name			
<b>ABSENT PARENT INCOME INFORMATION</b>						
Last Known Employer	Name, Address & Telephone					
Second Employer	Name, Address & Telephone					
Other Income/Benefits Received by absent parent:						
		<input type="checkbox"/> Social Security	<input type="checkbox"/> SSI	<input type="checkbox"/> Veteran's Pension	<input type="checkbox"/> Unemployment	
		<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Pension/Retirement	<input type="checkbox"/> Union Benefits	<input type="checkbox"/> Other, list _____	
<b>ABSENT PARENT COURT ORDER INFORMATION</b>						
Paying Support? <input type="checkbox"/> YES <input type="checkbox"/> NO	To Whom?		Last Date Paid		Payment Amount	
Court Ordered? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, where was the court order issued?				Can you give us a copy? <input type="checkbox"/> YES <input type="checkbox"/> NO	

—GO TO NEXT PAGE—  
You may attach extra pages if you need more space.

**PLEASE READ YOUR CUSTOMER RIGHTS AND RESPONSIBILITIES UNDER THE MEDICAL ASSISTANCE/MCHP PROGRAM,  
(LOCATED ON THE NEXT PAGE), BEFORE SIGNING BELOW.**

**SIGNATURE SECTION**

I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of Maryland to make any necessary contacts to check my statements. I have read and agree to the rights and responsibilities in this application packet. I know that I can be penalized if I knowingly give false information, and I declare under penalty of perjury that the facts I state in this application are true, correct, and complete to the best of my ability, belief, and knowledge.

Signature of Applicant/Recipient	Print (Name)	Date
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Signature of Witness (If you signed an X)	Print (Name)	Date
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Signature of Spouse (If Applicable)	Print (Name)	Date
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Signature of Authorized Representative (If Applicable)	Print (Name)	Date
Relationship to Applicant	Telephone Number of Authorized Representative	

**Customer Rights and Responsibilities**  
**Maryland Medical Assistance (MA) Program/MCHP**  
**Please read with care before signing application.**

**Health Care Benefits** I know I have the right to request and, if found eligible, to receive MA/MCHP benefits based on policies and standards established under Maryland law. If I am applying as a pregnant woman, I understand that abortion is not a covered service. Only use your MA/MCHP card if you are eligible.

**Confidentiality** I understand that the information I have given is confidential. I agree that medical information about my children or me can be released when the law allows.

**Personal and Financial Information** I agree to the release of personal and financial information from this application form to the agencies determining eligibility. I give permission for officials of the Maryland MA/MCHP Program to verify all information on this form. I understand I may be asked to provide additional information.

**Social Security Number (SSN) and Immigration Status** I understand that providing the SSNs of MA/MCHP applicants is required and that providing the SSNs of other non-applicant household members is voluntary. I will not be penalized if the SSNs of household members who are not applying for MA/MCHP are not provided. Neither SSNs nor immigration status will be shared with federal immigration authorities. They will only be used to help check the information about income and insurance coverage and to help maintain eligibility files. If I do not have a SSN and want to apply for one, I understand that my case manager will help me. **Providing a SSN is not required for Emergency MA/MCHP applicants. Applicants who do not have proper immigration status may still be eligible for Emergency MA, including labor and delivery, if they meet all other eligibility requirements.**

**Proof of Citizenship and Identity** I understand that all applicants declaring to be U.S. Citizens by birth or naturalization must provide documentation of citizenship and identity. See attached list of acceptable proof of citizenship/identity located on back of cover page. Applicants who are not yet U.S. citizens will be asked to submit other proof of identity and immigration status.

**Civil Rights** I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief. I know that I may request a hearing if I believe the State of Maryland in processing my application has made an error or if I feel I have been discriminated against. I have the right to appeal any action taken by the Department. If I ask for a hearing, my case manager can help me put my request in writing. At my hearing, I can speak for myself or have someone else represent me. I have a right to a written notice of all decisions affecting my eligibility.

**Assignment of Support Rights for MA/MCHP** When I am eligible for MA/MCHP, I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving MA/MCHP. This includes overdue medical support or health insurance payments that have not been collected. I agree to have the child support enforcement agency collect medical support payments owed on behalf of any child receiving MA/MCHP payments that were made. I agree to give the State of Maryland medical support or health insurance payments I receive. I will cooperate to the best of my ability and knowledge with the child support enforcement agency while I am receiving MA/MCHP. Unless I am exempt or the State finds that I have good cause, I may lose all my benefits and my case may be closed if I do not cooperate with the child support enforcement agency. However, no child's case would be closed.

**Third Party Payments And Cooperation With Quality Control Review** I understand that I am required by law to assign to the State all rights to medical support and other third party payments (hospital and medical benefits) and to cooperate with the State's MA/MCHP quality control review process including verification of all information pertinent to the determination of eligibility.

**Reporting Changes** I have a responsibility to report all changes that might affect eligibility within ten (10) days of the change. Examples of changes I must report are changes in the number of people in the household, address, income, employment and pregnancy. I can report changes in person, by telephone, or by mail to my case manager at my local health department or local department of social services.

**Fraud** Every person convicted of "Medical Assistance Fraud" with a value of \$500 or more in money, services or goods is guilty of a felony, and shall pay back money, services or goods; or the value of those services or goods unlawfully received. Be subject to a fine of no more than \$10,000, imprisoned for no longer than five years, or both. Every person convicted of "Medical Assistance Fraud" with a value of less than \$500 or more in money, services or goods is guilty of a misdemeanor, and shall pay back money, services or goods; or the value of those services or goods unlawfully received. Be fined no more than \$1,000 and imprisoned for no longer than three years, or both.

**REMINDER: Before mailing, did you:**

- **Sign and date the application?**
- **Include proof of citizenship and identity?**

**LOCAL HEALTH DEPARTMENT**

<p>Allegany Maryland Children's Health Program 12501 Willowbrook Rd. P.O. Box 1745 S.E. Cumberland, MD 21502 (301) 759-5076 (301) 777-2097 FAX</p> <p>Anne Arundel County Department of Health Maryland Children's Health Program 1 Harry S. Truman Pkwy. Suite 200 Annapolis, MD 21401 (410) 222-4792 (410) 222-4391 FAX</p> <p>Baltimore County Baltimore County Health Department MCHP Program 8501 LaSalle Rd. Suite 103 Towson, MD 21286 (410) 887-2957 (410) 887-8095 FAX</p> <p>Calvert Maryland Children's Health Program P.O. Box 980 Prince Frederick, MD 20678 (410) 535-5400 (301) 855-1353 (410) 535-1955 FAX</p> <p>Caroline Caroline County Health Department P.O. Box 10 (Mail Only) 403 S. 7<sup>th</sup> Street Denton, MD 21629 (410) 479-8004 (410) 479-0244 FAX</p> <p>Carroll County Health Department 290 S. Center Street P.O. Box 845 Westminster, MD 21158 (410) 876-4916 (410) 876-4905 FAX</p>	<p>Cecil Maryland Children's Health Program 401 Bow Street Elkton, MD 21921-5511 (410) 996-5126 (410) 996-5124 FAX</p> <p>Charles Co. Nursing &amp; Community Health Services P.O. Box 1050 White Plains, MD 20695-1050 (301) 609-6869/70/71/37 (301) 609-6899 FAX</p> <p>Dorchester Dorchester County Health Department 503-B Muir Street Cambridge, MD 21613 (410) 228-3294 (410) 228-8976 FAX</p> <p>Frederick Frederick County Health Department 350 Montevue Lane Frederick, MD 21702 (301) 600-1324 TEL (301) 600-3111 FAX</p> <p>Garrett 1025 Memorial Drive Oakland, MD 21550 (301) 334-7720 (301) 334-7771 FAX</p> <p>Harford Maryland Children's Health Program 119 S. Hays St. P.O. Box 797 Bel Air, MD 21014 (443) 643-0343 (443) 643-0344 FAX</p> <p>Howard County Health Department 7180 Columbia Gateway Drive Columbia, MD 21046 (410) 313-7500 (410) 313-7502 FAX</p>	<p>Kent County Health Department Maryland Children's Health Program 125 S. Lynchburg Street Chestertown, MD 21620 (410) 778-7023 (410) 778-7019 FAX</p> <p>Montgomery Service Eligibility Unit 1335 Piccard Drive, Upper Level Rockville, MD 20850 (240) 777-3120 (240) 777-1013 FAX</p> <p>8630 Fenton Street, 10<sup>th</sup> floor Silver Spring, MD 20910 (240) 777-3066 (240) 777-1307 FAX</p> <p>12900 Middlebrook Road Germantown, MD 20874 (240) 777-3591 (240) 777-3563 FAX</p> <p>Prince George's Maryland Children's Health Program 425 Brightseat Road, Suite 101 Landover, MD 20785 (888) 561-4049 (301) 324-2809 FAX</p> <p>Queen Anne's 206 N. Commerce Street Centreville, MD 21617 (410) 758-0720 (443) 262-9357 FAX</p> <p>St. Mary's MCHP Eligibility &amp; Outreach P.O. Box 316 21580 Peabody Street Leonardtown, MD 20650-0316 (301) 475-4275 (301) 475-4350 FAX</p>	<p>Somerset Somerset County Health Department 7920 Crisfield Highway Westover, MD 21871 (443) 523-1700 (410) 651-2572 FAX</p> <p>Talbot County Health Department 100 S. Hanson St. Easton, MD 21601 (410) 819-5600 (410) 819-5691 FAX</p> <p>Washington Maryland Children's Health Program (240) 313-3330 1302 Pennsylvania Avenue Hagerstown, MD 21742 (240) 313-3334 FAX</p> <p>Wicomico Maryland Children's Health Program (Mail Only) 108 E. Main Street (In Person) 300 West Carroll St. Salisbury, MD 21801 (410) 543-6944 (410) 543-6568 FAX</p> <p>Worcester Berlin Health Center 9730 Healthway Drive Berlin, MD 21811 (410) 629-0164 (410) 957-2005 (410) 629-0185 FAX</p> <p>Baltimore City Baltimore Health Care Access MCHP One Calvert Plaza 201 E. Baltimore Street 9<sup>th</sup> Floor Baltimore, Md. 21202 (410) 649-0512 (410) 649-0533 FAX</p>
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**REMINDER: Before mailing, did you:**

- **Sign and date the application?**
- **Include proof of citizenship and identity?**

**LOCAL DEPARTMENT OF SOCIAL SERVICES**

<p>BALTIMORE CITY DSS Talmadge Branch Building (Walk In) 1910 N. Broadway Baltimore, MD 21213 P.O. Box 17466 (Mail Only) Baltimore, MD 21203-7466 443-423-6300 443-423-6501 FAX</p> <p>ALLEGANY COUNTY DSS 1 Frederick Street Cumberland, MD 21502 301-784-7000 301-784-7222 FAX</p> <p>ANNE ARUNDEL COUNTY DSS 80 West St 2<sup>nd</sup> Floor Deck Annapolis, MD 21401 410-269-4500 410-974-8566 FAX Glen Burnie: 410-421-8550</p> <p>BALTIMORE COUNTY DSS 6401 York Road Towson, MD 21212 410-853-3000 410-853-3955 FAX Catonsville: 410-853-3450 Dundalk: 410-853-3400 Essex: 410-853-3800 Reisterstown: 410-853-3010</p> <p>CALVERT COUNTY DSS 200 Duke Street Prince Frederick, MD 20678-0100 443-550-6900 410-286-7429 FAX</p> <p>CAROLINE COUNTY DSS 300 Market Street Denton, MD 21629 410-819-4500 410-819-4501 FAX</p> <p>CARROLL COUNTY DSS 10 Distillery Drive Westminster, MD 21157 410-386-3300 410-386-3429 FAX</p> <p>CECIL COUNTY DSS Elton District Court/ Multi-Service Building 170 E. Main Street Elkton, MD 21921 410-996-0100 410-996-0464 FAX Calls from Rising Sun: 410-658-2145</p>	<p>CHARLES COUNTY DSS 200 Kent Avenue LaPlata, MD 20646 301-392-6400 301-870-3958 FAX</p> <p>DORCHESTER COUNTY DSS P.O. Box 217 (Mail Only) 627 Race Street (Walk In) Cambridge, MD 21613 410-901-4100 410-901-1047 FAX</p> <p>FREDERICK COUNTY DSS P.O. Box 237 (Mail Only) Frederick, MD 21705 100 E. All Saints Street (Walk In) Frederick, MD 21701 301-600-4555 301-600-4550 FAX</p> <p>GARRETT COUNTY DSS 12578 Garrett Highway Oakland, MD 21550-0556 301-533-3000 301-334-5449 FAX</p> <p>HARFORD COUNTY DSS 2 South Bond St Bel Air, MD 21014 410-836-4700 410-836-4945 FAX 410-879-4500</p> <p>HOWARD COUNTY DSS 7121 Columbia Gateway Dr. Columbia MD, 21046 410-872-8700 410-872-4231</p> <p>KENT COUNTY DSS 350 High Street P.O. Box 670 Chestertown, MD 21620 410-810-7600 410-778-1497 FAX</p> <p>MONTGOMERY COUNTY DHHS 401 Hungerford Drive, 5<sup>th</sup> Floor Rockville, MD 20850 240-777-1245 240-777-1342 FAX Germantown: 240-777-3420 240-777-3261 FAX Silver Spring: 240-777-3075 240-777-1002 FAX</p>	<p>PRINCE GEORGE'S COUNTY DSS 425 Brightseat Road Landover, MD 20785 301-909-6000 301-909-6067 FAX Hyattsville: 301-209-5000 301-209-5276 FAX South County: 301-316-7700 301-316-7701 FAX</p> <p>QUEEN ANNE'S COUNTY DSS 125 Comet Drive Centreville, MD 21617 410-758-8000 410-758-8110 FAX</p> <p>ST MARY'S COUNTY DSS Joseph D. Carter Building 23110 Leonard Hall Drive P.O. Box 509 (Mail Only) Leonardtown, MD 20650 240-895-7000 240-895-7099 FAX</p> <p>SOMERSET COUNTY DSS P.O. Box 369 (Mail Only) 30397 Mt. Vernon Road Princess Anne, MD 21853 410-677-4200 410-677-4300 FAX</p> <p>TALBOT COUNTY DSS 301 Bay Street P.O. Box 1479 (Mail Only) Easton, MD 21601 410-770-4848 410-820-7117 FAX</p> <p>WASHINGTON COUNTY. DSS 122 N. Potomac Street P.O. Box 1419 (Mail Only) Hagerstown, MD 21740 240-420-2100 240-420-2299 FAX</p> <p>WICOMICO COUNTY DSS 201 Baptist Street, Suite 27 Salisbury, MD 21801 410-713-3900 410-713-3910 FAX</p> <p>WORCESTER COUNTY DSS 299 Commerce Street P.O. Box 39 (Mail Only) Snow Hill, MD 21863 410-677-6800 410-677-6810 FAX</p>
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Zip Code