

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)			
What language do you speak? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ Do you have any unpaid medical bills from the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what month(s)? _____ Are you or anyone in your household pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____ Due Date _____ Are you or anyone in your household disabled? <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	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.

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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

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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?

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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"/> Changed Employer	<input type="checkbox"/> Terminated From Job	<input type="checkbox"/> Employer Dropped Coverage
<input type="checkbox"/> Moved Out of Service Area of Employer's Health Plans	<input type="checkbox"/> Quit Job	<input type="checkbox"/> Cost
<input type="checkbox"/> Dropped Limited Benefit Insurance (Vision, Dental, Not Hospital)	<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

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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.

SECTION I. CHILD SUPPORT INFORMATION						
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.						
#1 ABSENT PARENT (AP) INFORMATION						
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)				
Current or Prior Military		Paying Military Allotment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Military Branch		
Dates: From: To:		If yes, To whom?				
Incarcerated <input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never			Institution Name			
ABSENT PARENT INCOME INFORMATION						
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	
ABSENT PARENT COURT ORDER INFORMATION						
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	

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#2 ABSENT PARENT (AP) INFORMATION					
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)			
Current or Prior Military 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			
ABSENT PARENT INCOME INFORMATION					
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 _____	
ABSENT PARENT COURT ORDER INFORMATION					
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	

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**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	

**SEAL WITH TAPE HERE
DO NOT STAPLE**

Place
Stamp
Here

From: _____

TO: _____

Street Address

City

State

Zip Code