

Maryland Department of Health and Mental Hygiene
Office for Genetics and Children with Special Health Care Needs
Application for Children's Medical Services (CMS)

Return to:

Children's Medical Services
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 421A, Baltimore, MD 21201-2399
Phone: (410) 767-5585 Toll Free: 1-(800)-638-8864 Fax: (410) 333-7956

Office Use Only Date Received:

NEW APPLICATION

RENEWAL APPLICATION

1. APPLICANT INFORMATION

Applicant's Last Name _____ First Name _____ MI _____

Social Security Number (if any): _____ - _____ - _____

Date of Birth _____ Sex: Male Female

Address _____

City _____ County _____ State _____ Zip _____

Phone () _____ - _____ Alternate Phone () _____ - _____ Cell Phone () _____ - _____

Marital Status: Single Married

Race (check one)	Ethnicity (check one)
<input type="checkbox"/> White	<input type="checkbox"/> Hispanic
<input type="checkbox"/> Black	<input type="checkbox"/> Non-Hispanic
<input type="checkbox"/> American Indian	<input type="checkbox"/> Unknown
<input type="checkbox"/> Asian or Pacific Islander	
<input type="checkbox"/> Other	
<input type="checkbox"/> Unknown	

Is the applicant a citizen of the USA? Please note that US citizenship is not a requirement for eligibility.
 Yes No

What language is spoken in the home? : _____

2. MEDICAL INFORMATION

Name of person who referred you to CMS: _____

Address _____ Phone () _____ - _____

_____ Fax# () _____ - _____

Applicant's doctor or pediatrician: Name _____

Address _____ Phone () _____ - _____

_____ Fax# () _____ - _____

List medical problems of applicant:

- 1) _____
- 2) _____
- 3) _____

Describe care or service requested: _____

Are hospital services requested? No Yes If yes, please specify Inpatient Outpatient

When and where is the care needed (location and date of service)?

If requesting pharmacy assistance, indicate pharmacy you would use:

*** Please note, Children's Medical Services typically provides pharmacy assistance through Giant Pharmacies.**

Name _____ Phone () _____ - _____

Address _____

3. FAMILY INFORMATION

Last Name	First Name	MI	Address
Mother: _____	_____	_____	_____
Father: _____	_____	_____	_____
Legal Guardian: _____	_____	_____	_____

Please list all family members living in the applicant's household who are **dependents**. A dependent is a person who relies on other people for financial support.

***Put a check before name(s) of family members who already receive CMS services.

Name	Relationship to applicant	Birth date
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____

4. FAMILY INCOME AND EXPENSES

Mother: _____
Employer Occupation Work Phone Number

Mother's total gross earnings from wages and tips **per week**: \$ _____
(Gross income means the amount before taxes are taken out)

Did mother become unemployed during the last 12 months? Yes No

If yes, is she unemployed now? Yes No If yes, when was her last day of work? Date: _____

If she is working now, when did she return to work? Date: _____

Amount of income for 6 months before re-employment: \$ _____

Amount of wages expected for the 6 months following re-employment: \$ _____

Father: _____
Employer Occupation Work Phone Number

Father's total gross earnings from wages and tips **per week**: \$ _____
(Gross income means the amount before taxes are taken out).

Did father become unemployed during the last 12 months? Yes No

If yes, is he unemployed now? Yes No If yes, when was his last day of work? Date: _____

If he is working now, when did he return to work? Date: _____

Amount of income for 6 months before re-employment: \$ _____

Amount of wages expected for the 6 months following re-employment: \$ _____

Who claims the applicant as a dependent on Federal Income Tax forms, if anyone?

Last Name _____ First Name _____ MI _____

Other Income (per month):

Child Support \$ _____

Unemployment Insurance \$ _____
Begin _____ End _____

Workman's Compensation \$ _____
Begin _____ End _____

Disability Benefits \$ _____
including SSI

Temporary Cash Assistance \$ _____
(TCA)

Insurance Payments received \$ _____

Retirement/Pension Benefits \$ _____

Social Security Benefits \$ _____

Veterans Benefits \$ _____

Trust Fund Income \$ _____

Additional Income:

Includes alimony, income from boarders, income or cash contributions from relatives or other persons, income from property rentals, mortgage income, interest, dividends, royalties, or other income accrued to savings accounts, stocks, bonds, and insurance, and money received from other sources.

Additional Total per month: \$ _____

If you report no income, have you applied for public assistance? Yes No

Please explain how rent/food are provided for the applicant: _____

Expenses you pay out for all members of the family

Child Care for working parents only PER MONTH \$ _____

Child Support paid out PER MONTH \$ _____

Loan Payments due to medically related debt PER MONTH \$ _____

Health/Hospitalization Insurance premiums paid out PER MONTH \$ _____

Other (alimony, etc.) PER MONTH \$ _____

Payments to a hospital or other health care provider (for all family members) you paid yourself in the last 12 months.

	Total Bill	Paid	Balance Due
Doctors	\$ _____	\$ _____	\$ _____
Dentists	\$ _____	\$ _____	\$ _____
Hospital(s)	\$ _____	\$ _____	\$ _____
Prescription Drugs	\$ _____	\$ _____	\$ _____
Eye care/glasses	\$ _____	\$ _____	\$ _____
Special services/equipment (list)	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____

5. OTHER BENEFIT INFORMATION

Has application been made to Medical Assistance (MA) or MCHP in the past six months? Yes No
If yes, is the applicant eligible? Yes MA/MCHP Number _____
 No If no, attach a copy of denial letter. Pending

Has application been made for SSI benefits in the past six months? Yes No
If yes, is the applicant eligible for SSI benefits? Yes No Pending

Is the applicant receiving services through any other program?

- Infants and Toddlers Program (birth to 3 years) services
- Special Education/Child Find services
- Mental Health services
- Developmental Disabilities Administration services
- Other (please specify) _____

Is applicant covered by health insurance or a member of an HMO? Yes No

If applicant is covered by health insurance or is a member of an HMO, give name of Plan (s).

1. Insurance Company, Union Local, or HMO _____
Please check: medical/surgical pharmacy dental vision

Name of Policyholder _____

Address _____

Policy Identification number _____

2. Insurance Company, Union Local, or HMO _____
Please check: medical/surgical pharmacy dental vision

Name of Policyholder _____

Address _____

Policy Identification number _____

Person/Agency assisting with completion of application:
Name: _____

Agency/Company: _____

Address: _____

Phone: _____ Fax: _____

**AGREEMENT WITH
THE OFFICE FOR GENETICS AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS
FOR CHILDREN'S MEDICAL SERVICES**

I certify that all the information on this application form for Children's Medical Services (CMS) is true, correct, and complete. I understand that any false statement would subject me to penalties under Federal or State law and would result in a denial of program eligibility. I shall inform CMS or the local health department within 10 business days of any change in financial status.

I authorize the release to CMS of all data, records, and information by insurance companies, providers of medical care, financial institutions, federal, state, or local governmental agencies, and any other persons, agencies, or organizations necessary for CMS's pursuit of third party reimbursement or verification of statements provided by me or any other persons whose income and resources will be considered in this application. I understand that this signed application serves as written authorization for any of the above persons, agencies or organizations to release the information required.

I understand that CMS regulations must be followed regarding use of other third party coverage before CMS can pay for any services. I agree to file an insurance claim for any service that insurance may cover. I further agree to refund to CMS any insurance settlements or court-awarded damages which include compensation for health care expenses paid by CMS. Such refund shall not exceed the amount spent by CMS.

I understand that CMS can only pay for services that are provided by those health care providers approved by CMS.

I understand that CMS can only pay for services that have been approved by CMS before the service is provided.

I understand that I have a right to a meeting or informal conference with CMS staff responsible for a decision reflected in any notice of determination issued. I further understand that if, at any time, I disagree with the decision(s) regarding eligibility for services, I may file an appeal requesting a hearing under the provision of Health-General Article § 2-207, and State Government Article Title 10, Subtitle 2, Annotated Code of Maryland.

I understand that my personal medical record is confidential and may be disclosed only in accordance with Federal or State laws.

Name of Applicant (Please print)

Date of Birth

Signature of Parent(s)/Guardian/Applicant

Date

Signature of Witness

Date

**INSTRUCTIONS FOR COMPLETING AN APPLICATION FOR
CHILDREN’S MEDICAL SERVICES (CMS)**

GENERAL INSTRUCTIONS:

1. A parent or legal guardian should fill out the form for a dependent child less than 22 years of age.
2. Applicants 18-21 years of age who are not claimed as dependent by their parents should fill out the form themselves.
 - a. In Section 4: FAMILY INCOME AND EXPENSES, the applicant should cross out “Mother” and write “Self.” The applicant should fill out his or her own income information in the spaces following.
 - b. If the applicant is married, the spaces for father’s income should be used to record the spouse’s income information. Cross out “Father” and write “Spouse.”
3. A parent, legal guardian, or the applicant, if he or she is age 18-21 years of age and capable, must sign the agreement sheet on the last page of the application.
4. **Be sure to fill out all questions and print clearly.** The CMS Program cannot decide if a child can get help from the program if there is missing information.
5. **You may ask someone to help you fill out the form.** Staff in the local health department or hospital may help you. You can also call the Office for Genetics and Children with Special Health Care Needs at **1-(800)-638-8864** for help.
6. The completed application must be turned in to the Children’s Medical Services office along with the documents listed below. The application may also be faxed to (410) 333-7956.

Send the application to:

Children’s Medical Services
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 421A
Baltimore, MD 21201-2399

DOCUMENTS THAT MUST BE SENT IN WITH THE APPLICATION:

1. **Proof of identity.** Documents must be sent in that contain **both the name and date of birth** of the applicant and his or her parents or legal guardians if the applicant is a dependent child. Examples of documents that may be sent in include **(Photo ID is preferable)**:
 - Driver’s License;
 - Maryland MVA ID;
 - Passport;
 - Consulate ID;
 - Employment ID card;
 - School ID card.
 - Birth certificate;
 - Adoption record;
 - Marriage license;
 - Military service papers;
 - Voter registration card;
2. **Proof of Maryland residency.** Documents must be sent in with name(s) and current address for the applicant or his or her parents or legal guardians if the applicant is a dependent child. Examples of documents that may be sent in include:
 - Recent rental or room and board receipts (with identifying address);

- Property ownership records (deed or mortgage payment records);
- Driver's license or automobile registration;
- Employer's records of home address;
- Voter registration card;
- Local post office records;
- Rental lease;
- Utility bill;
- School verification.

3. Proof of income from employment. The following forms must be sent in:

- Copies of the two most recent pay stubs for each employed adult in the applicant's household
or
- A signed and dated statement from the employer(s) showing regular (gross) pay before deductions.
AND
- A copy of the most recent signed and dated Federal Income Tax forms
(If the application is filled out right before the tax filing deadline, a copy of the most recent W-2 forms for each employed adult).
- **NOTE: If the applicant is self-employed, only a copy of the most recent signed and dated Federal Income Tax forms need to be submitted.**

4. Proof of other income. Copies of award letters must also be sent in as proof of income for adult family members who receive income from other sources. These sources include monies from:

- Temporary Cash Assistance (TCA);
- Unemployment insurance;
- Workman's compensation;
- Supplemental Security Income (SSI);
- Retirement or pension funds;
- Life insurance payments;
- Social security benefits;
- Veteran's benefits;
- Child support payments.

5. Proof of expenses. Documents must be sent in as proof of all family expenses listed on the application. This includes documentation of the following:

- Child care expenses - ex. receipts, written statement from child care provider;
- Child support payments or alimony - ex. court orders, support agreements;
- Health insurance premium payments - ex. pay stub with insurance deductions, written statement from insurance company;
- Other medical expenses - ex. receipts, insurance explanation of benefits, loan statement from financial institution.

6. Proof of medical eligibility. Documents must be sent in that show the applicant's diagnosis or suspected diagnosis and the need for specialty care and/or related services like medications and medical equipment. Examples of documents that may be sent in include the following, **dated within the past 6 months:**

- Medical provider visit notes;
- Hospital discharge summary;
- Medical consultation reports;

- Letter from medical provider.

7. Proof of other insurance (if applicable). If the applicant, parents or legal guardians have other health insurance, send a copy (front and back) of the insurance card.

- If the applicant no longer has other health insurance, send a copy of the statement from the insurance company stating the applicant is no longer covered.
- If a requested service has been denied by the insurance company, send a written copy of the denial by the insurance company.

***Additional information may be requested when processing the CMS application. ***