Rev. 07/12

Office Use Only
Date Received:

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

Return to: Children's Medical Services
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 423, Baltimore, MD 21201-2399
Phone: (410) 767-5588 Toll Free: 1-(800)-638-8864 *** FAXED APPLICATIONS ARE NOT ACCEPTED***

[ ] 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

Ethnicity (check one)	Race (check one)	
☐ Hispanic	☐ White	☐ Asian or Pacific Islander
☐ Non-Hispanic	☐ Black	☐ Other
☐ Unknown	☐ American Indian	☐ 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**
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____

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 <u>pay out</u> 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: _____

REIMBURSEMENT & COVERAGE AGREEMENT
and
AUTHORIZATION TO RELEASE INFORMATION

THE OFFICE FOR GENETICS AND PEOPLE WITH SPECIAL HEALTH CARE NEEDS
FOR CHILDREN'S MEDICAL SERVICES PROGRAM

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. 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 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.

_____	_____
Name of Applicant (Please print)	*Date of Birth*
_____	_____
Signature of Parent(s)/Guardian/Applicant	*Date*
_____	_____
Signature of Witness	*Date*