Charles County Department of Health

MCHP APPLICATION – PLEASE PRINT ALL ANSWERS

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 ☐

Was anyone recently released from incarceration? YES ☐ NO ☐

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
- ☐ Receive Notices
- ☐ Sign your application
- ☐ Receive your Medical Cards

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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**

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- **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

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-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: _____