Maryland
DEPARTMENT OF HEALTH

# APPLICATION FOR EMERGENCY MEDICAL SERVICES FOR UNDOCUMENTED OR UNQUALIFIED ALIENS

*Fill this out, print it and sign it. Mail or drop it off at your local Department of Social Services or local Health Department.*

**WHO CAN USE THIS APPLICATION:**

☐Undocumented alien

☐Unqualified alien (not residing in the US with a Permanent Resident Status for 5 or more years; or not Lawfully Present and pregnant; or not Lawfully Present and under age 21).

**WHO CANNOT USE THIS APPLICATION:**

☐ US Citizen ☐US National
☐ Asylee ☐Refugee
☐ Residing in the US with a Permanent Resident Status for 5 or more years
☐Lawfully Present and pregnant
☐Lawfully Present and under age 21

If you cannot use this application and you are under 65 years old, please apply through marylandhealthconnection.gov.

If you cannot use this application and you are 65 years old or older, please apply through mydhrbenefits.dhr.state.md.us.

1. _____ _____ _____ _____
Applicant's First name Middle name Last name Suffix (Jr., Sr., etc.)

2. Gender: ◯ Male ◯ Female 3. Social Security Number: _____ 4. Date of Birth: _____

5. Are you applying for a Social Security Number? ◯ No ◯ Yes ITIN # _____

6. Check the reason for the application: Select One

7. Other household members besides the applicant:

| First name | Middle name | Last name | Date of Birth | Relationship to the Applicant |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

8. Marital Status: Select One

Name of Spouse: _____ Social Security Number: _____

9. Home Address: _____
Street # Street Name . City/Town State Zip Code Apt. or suite # County

I am a resident of Maryland, but I cannot get mail at my home address, so please use this mailing address.

10. Mailing address: _____ Same as Home ☐
Street # Street Name . City/Town State Zip Code Apt. or suite #

11. Phone number: _____ 12. Other phone number: _____

13. Email address, if you want to get information about this application by email: _____

14. Do you have a visual impairment? ◯ No ◯ Yes 15. Do you need American Sign Language due to hearing loss? ◯ No ◯ Yes

16. Do you want to receive paper notices? ☐Yes (only paper for now) 17. Preferred spoken or written language: Select One

18. Tax Filing Status for each of these years: 2020: Select One 2019: Select One 2018: Select One

19. Are you pregnant? ◯ No ◯ Yes → Expected Due Date: Actual Due Date: How many babies? _____

20. Are you currently disabled? ◯ No ◯ Yes 21. Are you currently incarcerated? ◯ No ◯ Yes

22. What is your immigration status? Select One

HOUSEHOLD INCOME: Your household income includes gross earnings, such as wages, salaries and tips. If you are self-employed, your income is the net income from your business after deducting business expenses. Your income also includes other types of unearned income, like Social Security Benefits, Investment Income, Pension income and Rental Income.

23. Do you or any of your household members have any income to report for this month? ◯ No ◯ Yes

24. Will the income vary or change over the 12-month period starting with the current month? ◯ No ◯ Yes

25. What is your total household income for this month? $_____

26. What will be your household income for this calendar year? $_____ (this can be your best guess for the entire year)

27. For any member of the household who is employed:

| Name of Household Member | Employer's Name | Amount Paid Before Taxes | How Often Received? | # Hours Per Week? | # Days Per Week? | End Date (if no longer employed) |
|---|---|---|---|---|---|---|
| | | $ | | | | |
| | | $ | | | | |
| | | $ | | | | |

28. For any member of the household who is self-employed:

| Name of Household Member | Name of Company | Type of Company | Amount Paid Before Taxes | How Often Received? | # Hours Per Week? | # Days Per Week? | End Date if no longer employed) |
|---|---|---|---|---|---|---|---|
| | | | $ | | | | |
| | | | $ | | | | |

29. For any member of the household who receives other income (such as Social Security Benefits, Investments, Pension, Rental Income):

| Name of Household Member | Source of Other Income | Amount Paid Before Taxes | How Often Received? | End Date (if income has ended) |
|---|---|---|---|---|
| | | $ | | |
| | | $ | | |

30. For any member of the household who has deductions from income (such as alimony paid, student loan interest, IRAs, capital loss):

| Name of Household Member | Deduction Type | Deduction Amount | How Often? | End Date (if income has ended) |
|---|---|---|---|---|
| | | $ | | |

31. FOR APPLICANT 65 YEARS OLD OR OLDER: HOUSEHOLD ASSETS: Report below all assets you or your spouse own, individually or jointly, as of the first of this month, such as cash, bank and savings accounts, draft account, stocks, bonds, 401(k) retirement accounts, trusts, certificates of deposit, motor vehicles, insurance policies, real estate property and other property.

| Name of Household Member | Name of Company | Type of Asset | Account Number | Start Date | End Date | Monthly Amount | Last Update Date |
|---|---|---|---|---|---|---|---|
| | | | | | | $ | |
| | | | | | | $ | |
| | | | | | | $ | |

AUTHORIZED REPRESENTATIVE: You can choose an authorized representative to assist in completing the application
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you are a legally appointed representative for someone on this application, submit proof with the application. Select the type of representative: ☐Court Appointed Representative and/or Power of Attorney ☐Responsible Adult

Name of Authorized Representative (First Name, Middle Name, Last Name)

Authorized Representative's Contact Information:

Street # | Street Name | City/Town | State | Zip Code | Apt. or suite # | Phone number

Organization name (if applicable) | ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on matters with this agency.

Applicant's Signature | Date (mm/dd/yyyy)

- I am signing this application under penalty of perjury, which means I have provided true and correct answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under state and federal law if I intentionally provide false or untrue information.
- I know that under state and federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, disability, or because of genetic information, and I can file a complaint of discrimination at www.hhs.gov/ocr/office/file or 1-800-368-1019 or 1-800-537-7697 (TDD).
- I know that my information on this form will be used only to determine eligibility for health coverage and will be kept private as required by law.
- I confirm that no one applying for health coverage on this application is incarcerated (detained or jailed).
- I agree to accept the assignment of interest terms and conditions. If Medicaid pays for any of my medical expenses, then any money I receive from a lawsuit or claim will be assigned to the State to pay for any medical expenses paid by the State related to injuries that led to the lawsuit or claim. If I have other insurance or a third party is liable to pay for my medical expenses, the State may recover the cost of my medical bills directly from the insurer or the third party. The State may bill a legally liable relative to repay the State for the costs of my medical care. The State may recover money from the estates of those people who were 55 years old or older at the time that community medical benefits were paid and who do not have a living spouse or surviving child under age 21 or blind or disabled. The State may recover from the inheritance or other lump sum of money I receive to repay the State for the costs of my medical care. The State may place a lien, under certain conditions, on my home if I permanently enter a nursing facility.

Applicant's or Authorized Representative's Signature | Signature Date (mm/dd/yyyy)