AFFIDAVIT OF OTHER INCOME

Complete this Affidavit if you have no other document to show your current income or recent change in income.

DATE: _____ APPLICATION ID: _____

NAME: _____ SSN OR TAX ID: _____

I _____, swear or affirm that the current monthly income of my household is

$ _____. The source of this income is _____

_____

_____

My monthly income has changed recently due to the following: _____

_____

_____

I understand that if I am determined eligible for Medicaid or a Qualified Health Plan that I must report any and all changes (including income, address, household members and pregnancy status) within 10 days to the Maryland Health Connection or my local health department or social services, or I can do this by logging into my online account at http://www.marylandhealthconnection.gov.

I hereby certify that the statements provided in this affidavit are true and accurate to the best of my knowledge.

_____ _____

SIGNATURE DATE