AFFIDAVIT OF SOCIAL SECURITY INCOME

DATE: _____ APPLICATION ID: _____

NAME: _____ SSN OR TAX ID: _____

I _____, swear or affirm that my current income consists of social security benefits in the amount of $ _____.

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

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.

_____ _____

SIGNATURE DATE

☐ I am unable to sign and scan.