MONTGOMERY COUNTY SAFETY-NET PROGRAMS APPLICATION

COUNTY OFFICIAL USE ONLY:

eICM Contact ID: _____

Case Number: _____

Head of Household Name (Last, First, Middle)	Home Telephone	Work Telephone	Cell Telephone

Where Do You Live? (Number and Street)	Apt. #	City	State	Zip Code

Mailing Address (If different from home address)

What language do you speak? ☐ **English** ☐ **Spanish** ☐ **Amharic** ☐ **French** ☐ **Korean** ☐ **Mandarin** ☐ **Vietnamese** ☐ **Other** _____

Are you or anyone in your household pregnant? ☐ **Yes** ☐ **No** **If yes, who?** _____ **Due Date** _____

Have you ever received a county health program benefit program? ☐**Yes** ☐**No** Under what name? _____

SECTION A. HOUSEHOLD MEMBERS

Fill in the blanks for all the people in your household. Check **YES** for each person you are applying for. Check **NO** for each person you are not applying for. Check services you are requesting.

Please complete for each person who has a Social Security number

APPLYING FOR	**NAME** (Last, First, Middle)	**RELATION TO YOU:**	**DATE OF BIRTH** MM/DD/YY	**GENDER** **M** =Male **F**= Female **NB=**Nonbinary **GQ** = Genderqueer/ Genderfluid **MTF** = Transwoman/ woman of transgender experience **FTM** = Transman/ man of transgender experience	**MARITAL STATUS** **M** = Married **S** = Single **D** = Divorced **P** = Separated **W** = Widowed	***RACE** (Indicate below for each person) A = Asian B = Black/African American C = White N = American Indian or Alaska Native P = Native Hawaiian or Pacific Islander (You may select more than one code) MENA = Middle Eastern or North African	***ETHNICITY** H/L = Hispanic/ Latino N/L = Non-Hispanic/ Non-Latino	**SOCIAL SECURITY NUMBER (SSN)**
☐ MONTGOMERY CARES ☐ CARE FOR KIDS ☐ SENIOR DENTAL								
☐ Yes ☐ No		SELF					☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	

***You do not have to give information about your race/ethnicity. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter codes for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.**

SECTION B. ADDITIONAL INFORMATION

Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based
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SECTION C. EARNED INCOME

Does anyone in your household receive any income from employment? ☐ Yes ☐ No If yes, list all gross income (from full or part-time employment, self-employment, babysitting, odd jobs, day work, roomer/boarder payments)

NAME (Last, First, Middle)	EMPLOYER	RATE OF PAY (HOURLY)	NUMBER OF HOURS WORKED	GROSS AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED WE = Weekly BW = Bi-weekly MO = Monthly	JOB START DATE (MM/DD/YY)	JOB END DATE (MM/DD/YY)	STUDENT STATUS (Full or Part-time)

SECTION D. UNEARNED AND OTHER INCOME

List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others, and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

PERSON RECEIVING INCOME	TYPE (For benefits, Include Claimant ID#)	GROSS AMOUNT RECEIVED	HOW MANY TIMES A YEAR?

SIGNATURE SECTION

I certify that the information I have provided above is true to the best of my knowledge and I give permission for Montgomery County to make any necessary contacts to check my statements. I have read and agree to the rights and responsibilities in this application packet. I know that I can be penalized if I knowingly give false information, and I declare under penalty of perjury that I do not have health insurance coverage and the facts I state in this application are true, correct, and complete to the best of my ability, belief, and knowledge.

Signature of Applicant/Recipient	Print (Name)	Date