Send your application and supporting documents to us at:
Calvert Healthcare Solutions
P.O. Box 1743
Lusby, MD 20657
or
Fax: 443-404-5762

Phone: (443) 404-5761
PLEASE PRINT CLEARLY

Applications can also be dropped off at:
Calvert Healthcare Solutions
11845 H. G. Trueman Road Lusby
or
Calvert Memorial Hospital
100 Hospital Road Prince Frederick
Attn: Case Management

Last Name	**First Name**	**Middle Name**

Social Security Number	**Date of Birth**	**Gender**	**U.S. Citizen/Permanent Resident?**
	/ /	**Male Female**	**Yes No**

Race/Ethnicity **(Circle all that apply)** **Hispanic African American Asian American Indian/Alaska Native White Native Hawaiian/Pacific Islander**

Marital Status **(Circle One) Never Married Married Divorced Separated Widowed**

If married, is your spouse living with you? (Circle One) Yes No

Household Size: **(Check all that apply) Yourself □ Spouse □**

The number of dependent children under the age of 19 years who live with you:0 □ 1 □ 2 □ 3 □ 4 □ 5 □

Dependent information: **Do your dependent children currently receive benefits from Maryland Children's Health Program? (Circle One) Yes No Not applicable**

Residence Information

Address	**City**	**State**	**Zip Code**
		MD	

Mailing Address Information **(if different from your residence)**

Address	**City**	**State**	**Zip Code**
		MD	

How long at this address? _______ **Own or Rent? (Circle One)**

Home Phone	**Work Phone**	**Cell Phone**

Email Address	**Work Phone**	**Cell Phone**

Employment History **Are you currently employed? (Circle One) Yes No**

Primary Employer	**City**	**State**	**Start Date**	**Hours per Week**
			/ /	

Monthly Income before Taxes	**Hourly Wage**	**How often are you paid? (Circle One)**
		Every Week Every 2 Weeks Once a Month

Were you offered Health Insurance? (Circle One) Yes No

If yes, why did you choose not to enroll? ____

Is your household currently receiving any other income? (Check all that apply and indicate amount and how often you are paid)

	Amount	How Often Paid (Every Week Every 2 Weeks Once a Month)	
☐ **Spouse's Income:**	________	____________	
☐ **Unemployment:**	________	____________	
☐ **Social Security:**	________	____________	
☐ **Disability:**	________	____________	
☐ **Other:**	________	____________	**(Please Describe Source):** ______________________________

If applying for just yourself, sign the application below. If married and your spouse is applying for membership, please complete spouse's information below before signing.

Spouse's Information

Last Name	**First Name**	**Middle Name**

Social Security Number	**Date of Birth**	**Gender**	**U.S. Citizen/Permanent Resident?**
	/ /	**Male Female**	**Yes No**

Race/Ethnicity **(Circle all that apply) Hispanic African American Asian American Indian/Alaska Native White Native Hawaiian/Pacific Islander**

Employment History **Are you currently employed? (Circle One) Yes No**

Primary Employer	**City**	**State**	**Start Date**	**Hours per Week**
			/ /	

Monthly Income before Taxes	**Hourly Wage**	**How often are you paid?**
		Weekly Bi-Weekly Monthly

Were you offered Health Insurance? (Circle One) Yes No

If yes, why did you choose not to enroll? ____

Authorization and Certification:

I hereby apply for services provided by Calvert Healthcare Solutions, Inc. I authorize Calvert Healthcare Solutions to verify the information contained in this application and the documentation provided to determine eligibility including use of my Social Security number to cross match information in federal, state, and local government files. I understand that the information on this application and submitted documentation will only be used for the purpose of determining eligibility and program administration and will be maintained as confidential under federal and state regulation. I have received a copy of the CHS Notice of Privacy Practices. I certify that all persons applying on this application are U.S. citizens or documented Permanent Residents *and* residents of Calvert County, Maryland. I further agree to provide notice of change in address, income, or health insurance coverage status to Calvert Healthcare Solutions within 14 days. I also agree to fulfill my financial obligations as a participant of the program as outlined in the Rights and Responsibilities form. The following supplementary documentation is acceptable:

For Residency – Maryland Drivers License or State Identification Card
For Income – Either 4 most recent pay stubs; ***or*** W2 form or front page of income tax filing if applying during January-March; ***or*** bank statement showing direct deposit information for 2 months; ***or*** Employer Certification form

I understand that Calvert Healthcare Solutions, Inc is not insurance or a substitute for the financial protections and extended coverage provided through health insurance.

Signature: ____ Date: ____________________

Spouse's Signature: ____ Date: ____________________

For CHS office use: Household Size: _____________ Total Household Income: ____________________
Staff Initials: ____________ Date Reviewed: ____________________