Reset Form Print Form

FACTS ABOUT APPLYING FOR MEDICAL ASSISTANCE (MA) FOR FAMILIES, PREGNANT WOMEN, AND CHILDREN & MARYLAND CHILDREN'S HEALTH PROGRAM (MCHP)

If you would like Temporary Cash Assistance (TCA) or Food Stamps, please contact your local Department of Social Services office (See attached list).

Instructions

- ☐ **I am a parent or other family member caring for children applying for myself and a child(ren)--*Please complete ALL Sections A-I for MA for Families and send application to the Local Health Department or Department of Social Services.***
- ☐ **I am pregnant and applying only for myself--*Please complete Sections A-H ONLY* and send application to the Local Health Department.**
- ☐ **I am applying for only a child(ren) (MCHP)--*Please complete Sections A-H ONLY* and send application to the Local Health Department.**

Social Security Numbers

- You must give us a social security number for each person who wants MA/MCHP.
- If a person who wants MA/MCHP does not have a Social Security Number, that person must apply for a number. We can help you apply.
- If a person has applied for a Social Security Number, we will not delay the application while waiting for the number.
- We use Social Security Numbers to prove income. We do not give them to other agencies like Citizenship and Immigration Services.

Income Information

- You may need to give proof of income.
- The other family members who give us their information will get MA/MCHP if they meet the eligibility guidelines.

Identity

- You must give proof of identity for each person who wants MA/MCHP. See attached citizenship and identity listing on the next page.

Citizenship and Immigration Status

- You must give proof of citizenship or immigration status for each family member who wants MA/MCHP. See attached citizenship and identity listing.

Emergency Medical Assistance

- If you are not a citizen or qualified alien and you are applying only for Emergency MA, you do not need to give a Social Security Number, immigration or citizenship status.

Application Process

- Please complete the application and mail, fax or bring it to your local health department (LHD) or local department of social services (LDSS). Addresses of the LHDs and the LDSSs are located on the last two pages of the application.
- You can also send your applications electronically through the Service Access & Information Link **(SAIL)** system at www.marylandsail.org.

If you need help applying for benefits, have questions, or do not speak English and need free translation services, please call 1-800-456-8900 or 1-800-332-6347.

Si necesita ayuda para Llenar el formulario favor de llamar al 1-800-456-8900 o 1-800-332-6347.

website: www.dhmh.state.md.us

PROCEDURES FOR PROVING CITIZENSHIP AND IDENTITY

For questions regarding citizenship and identity, please call 1-800-492-5231.

A. Use one of the following documents to prove ***both*** citizenship and identity:
   1. U.S. passport (current or expired), or
   2. Certificate of Naturalization (N-550 or N-570), or
   3. Certificate of Citizenship (N-560 or N-561).

OR

B. One document from the Proof of Citizenship list **AND** one document from the Proof of Identity list

Proof of Citizenship	**Proof of Identity**
• U.S. Birth Certificate • Data match of Vital Statistics records by DHMH to document birth record • Systematic Alien Verification for Entitlements (SAVE) - **for naturalized citizens only** • **For child under 16**: a record created near the date of birth, or 5 years before initial MA/MCHP application, and showing U.S. place of birth on hospital letterhead or other medical record. • Record showing U.S. place of birth, if created at least 5 years before initial MA/MCHP application: record on hospital letterhead or other medical record created near the date of birth, institutional admission papers, signed statement by physician or midwife who attended the birth, Vital Statistics notice of birth registration, insurance record • Final adoption decree for child born in U.S. • Certificate of citizen born abroad (DS-1350, FS-240, FS-545) • Early school record that shows a U.S. place of birth, the date of admission to the school, date of birth (or age at the time the record was made), and the name(s) and place(s) of birth of the applicant's parent(s) • Religious record - recorded in the U.S. within three months of birth showing US birth, and either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization, not the family bible • U.S. military service record showing U.S. place of birth • Evidence of U.S. civil service employment before 6/1/76 • Federal or state census record for 1900-1950 showing U.S. citizenship or U.S. place of birth • ID card for naturalized citizen (I-179 or I-197) • **Affidavits** (can also be used for naturalized citizens) Three written and signed affidavits. Two completed by citizens who have personal knowledge of the person's citizenship, one of whom is not a relative. Both signers must be US citizens. Another affidavit completed by the person, representative, or someone else knowledgeable to explain why the proof isn't available.	• Photo driver's license or Motor Vehicle Administration (MVA) ID card • Data match with other benefit programs (current or past TCA, Food Stamps, TDAP, SSI eligibility) to document identity • Photo school ID card • Photo ID issued by a federal, state, or local government • U.S. military ID card, discharge document, or draft record • Native American Tribal Document • US Coast Guard Merchant Mariner card • For children under 16: Clinic, doctor, hospital, or school record (e.g., DHR/FIA 604 or 604-A form), nursery or day care record including pre-school health forms and Form 1131. School records may include report cards but these records must be verified with the issuing school. • Three or more corroborating documents to prove identity such as marriage licenses, divorce decrees, high school and college diplomas, property deeds/titles, and employer ID cards. This process can be used if they are unable to produce a single, more reliable document such as a driver's license. (These may only be used if the individual did not use affidavits to verify citizenship.) Note: Recently expired identity documents are usable as long as there is no reason to believe the document does not match the individual. • Affidavits can be used for the following For Children under 16: written affidavit signed by parent or guardian- but only if an affidavit was not used as proof of citizenship Disabled individuals (Adult/Child) in long term care or rehabilitative residential care facilities; signed by Facility Director or Administrator.

Si necesita ayuda para llenar el formulario favor de llamar al 1-800-456-8900

MEDICAL ASSISTANCE (MA)/MCHP APPLICATION FOR FAMILIES, PREGNANT WOMEN, AND CHILDREN

Date Received (Agency use only)

✓ ***Please print a completed form and sign before submission by mail or fax.***

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 ☐ Other _____

Do you have any unpaid medical bills from the past 3 months? ☐ Yes ☐ No If yes, what month(s)? _____ _____ _____

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

Are you or anyone in your household disabled? ☐ Yes ☐ No If yes, who? _____ Disability? _____

Have you ever received assistance? ☐ Yes ☐ No

Under what name? _____

SECTION A. HOUSEHOLD MEMBERS

Fill in the blanks for all of the people in your household. Write **YES** for each person you are applying for. Write **NO** for each person you are not applying for.

Please complete for each person applying for Medical ⬇ Assistance/MCHP ⬇

APPLYING FOR MEDICAL ASSISTANCE/ MCHP Y = Yes N = No	NAME (Last, First, Middle)	RELATION TO YOU:	DATE OF BIRTH MM/DD/YY	GENDER M =Male F= Female	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 = Amer-Indian or Alaska Native P = Native Hawaiian or Pacific Islander (You may select more than one code)	*ETHNICITY H/L = Hispanic/ Latino N/L = Non-Hispanic/ Non-Latino	U.S. CITIZEN Y = Yes N = No (If No please complete section B)	SOCIAL SECURITY NUMBER (SSN)
☐Y ☐N		**SELF**					☐H/L ☐N/L	☐Y ☐N	
☐Y ☐N							☐H/L ☐N/L	☐Y ☐N	
☐Y ☐N							☐H/L ☐N/L	☐Y ☐N	
☐Y ☐N							☐H/L ☐N/L	☐Y ☐N	

*****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.

—GO TO NEXT PAGE—

You may attach extra pages if you need more space.

SECTION B. IMMIGRATION STATUS (For Non-Citizens Only)

Answer these questions for each non-citizen who wants Medical Assistance/MCHP. **IF YOU ARE APPLYING FOR EMERGENCY MEDICAL ASSISTANCE/MCHP, YOU DO NOT HAVE TO FILL IN SECTION B.**

Name (Last, First, Middle)	U.S. Entry Date:	Country of Origin:	Undocumented? ☐ Yes ☐ No
	USCIS Number:		
Name (Last, First, Middle)	U.S. Entry Date:	Country of Origin:	Undocumented? ☐ Yes ☐ No
	USCIS Number:		
Name (Last, First, Middle)	U.S. Entry Date:	Country of Origin:	Undocumented? ☐ Yes ☐ No
	USCIS Number:		

SECTION C. VOTER REGISTRATION

If anyone in your household is not registered to vote, would they like to receive voter registration forms?

☐ Yes How many?_____ ☐ No ☐ Already registered

SECTION D. EARNED INCOME

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

NAME (Last, First, Middle)	EMPLOYER (INCLUDE ADDRESS AND PHONE NUMBER)	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 E. DEPENDENT CARE

If anyone in your household pays someone to care for a child or disabled adult in the household, fill in this section:

Name of Care Provider	Telephone	Name of Care Provider	Telephone
Household Member Receiving Care		Household Member Receiving Care	
Who Pays?	Monthly Cost $	Who Pays?	Monthly Cost $
Do you have Purchase of Care Services/Vouchers through the Department of Social Services? ☐ Yes ☐ No		Do you have Purchase of Care Services/Vouchers through the Department of Social Services? ☐ Yes ☐ No	

SECTION F. CHILD SUPPORT/ALIMONY EXPENSE

Does any household member pay child support or alimony to a **NON-HOUSEHOLD** member? ☐ Yes ☐ No (Includes current payments, back payments, health insurance)

NAME OF PERSON PAYING	NAME OF PERSON OUTSIDE YOUR HOUSEHOLD WHO IS RECEIVING THESE PAYMENTS	MONTHLY AMOUNT PAID

—GO TO NEXT PAGE—

You may attach extra pages if you need more space.

SECTION G. 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?

NOTE: If you did not list any income in sections D & G, please describe how you get food and shelter?

SECTION H. HEALTH INSURANCE

Does anyone applying have Health Insurance? ☐ Yes ☐ No If yes, is it: (circle one) ☑ Private-Payer ☐ Employer-Based

If yes, please answer the following: HEALTH INSURANCE POLICY NUMBER 1

NAME OF POLICY HOLDER:		INSURANCE COMPANY NAME:
POLICY NUMBER:	GROUP NUMBER:	EFFECTIVE DATE (MM/DD/YY):

HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER

If yes, please answer the following: HEALTH INSURANCE POLICY NUMBER 2

NAME OF POLICY HOLDER:		INSURANCE COMPANY NAME:
POLICY NUMBER:	GROUP NUMBER:	EFFECTIVE DATE (MM/DD/YY):

HOUSEHOLD MEMBER(S) COVERED BY POLICY	RELATIONSHIP OF MEMBER TO POLICY HOLDER

Have you dropped employer-based health insurance coverage for the applicant within 12 months of filing this application? ☐ Yes ☐ No

If yes, please tell us when coverage dropped: ☐ 0 – 3 months ☐ 4 – 6 months ☐ 7 – 9 months ☐ 10 – 12 months

If yes, please tell us why coverage was dropped:
☐ Changed Employer ☐ Terminated From Job ☐ Employer Dropped Coverage
☐ Moved Out of Service Area of Employer's Health Plans ☐ Quit Job ☐ Cost ☐ No Longer Needed
☐ Dropped Limited Benefit Insurance (Vision, Dental, Not Hospital) ☐ COBRA Coverage Ended ☐ Other: _____

If a child is not eligible for free medical care, would you (the parent or guardian of the applicant) be willing to pay a premium payment each month to give the child health insurance coverage through MCHP Premium? ☐ Yes ☐ No

—GO TO NEXT PAGE—

You may attach extra pages if you need more space.

PLEASE READ YOUR CUSTOMER RIGHTS AND RESPONSIBILITIES UNDER THE MEDICAL ASSISTANCE/MCHP PROGRAM, (LOCATED ON THE NEXT PAGE), BEFORE SIGNING BELOW.

SIGNATURE SECTION

I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of Maryland 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 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

Signature of Witness (If you signed an X)	Print (Name)	Date

Signature of Spouse (If Applicable)	Print (Name)	Date

Signature of Authorized Representative (If Applicable)	Print (Name)	Date
Relationship to Applicant	Telephone Number of Authorized Representative	

Print Form

Customer Rights and Responsibilities
Maryland Medical Assistance (MA) Program/MCHP
Please read with care before signing application.

Health Care Benefits I know I have the right to request and, if found eligible, to receive MA/MCHP benefits based on policies and standards established under Maryland law. If I am applying as a pregnant woman, I understand that abortion is not a covered service. Only use your MA/MCHP card if you are eligible.

Confidentiality I understand that the information I have given is confidential. I agree that medical information about my children or me can be released when the law allows.

Personal and Financial Information I agree to the release of personal and financial information from this application form to the agencies determining eligibility. I give permission for officials of the Maryland MA/MCHP Program to verify all information on this form. I understand I may be asked to provide additional information.

Social Security Number (SSN) and Immigration Status I understand that providing the SSNs of MA/MCHP applicants is required and that providing the SSNs of other non-applicant household members is voluntary. I will not be penalized if the SSNs of household members who are not applying for MA/MCHP are not provided. Neither SSNs nor immigration status will be shared with federal immigration authorities. They will only be used to help check the information about income and insurance coverage and to help maintain eligibility files. If I do not have a SSN and want to apply for one, I understand that my case manager will help me. **Providing a SSN is not required for Emergency MA/MCHP applicants. Applicants who do not have proper immigration status may still be eligible for Emergency MA, including labor and delivery, if they meet all other eligibility requirements.**

Proof of Citizenship and Identity I understand that all applicants declaring to be U.S. Citizens by birth or naturalization must provide documentation of citizenship and identity. See attached list of acceptable proof of citizenship/identity located on back of cover page. Applicants who are not yet U.S. citizens will be asked to submit other proof of identity and immigration status.

Civil Rights I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief. I know that I may request a hearing if I believe the State of Maryland in processing my application has made an error or if I feel I have been discriminated against. I have the right to appeal any action taken by the Department. If I ask for a hearing, my case manager can help me put my request in writing. At my hearing, I can speak for myself or have someone else represent me. I have a right to a written notice of all decisions affecting my eligibility.

Assignment of Support Rights for MA/MCHP When I am eligible for MA/MCHP, I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving MA/MCHP. This includes overdue medical support or health insurance payments that have not been collected. I agree to have the child support enforcement agency collect medical support payments owed on behalf of any child receiving MA/MCHP payments that were made. I agree to give the State of Maryland medical support or health insurance payments I receive. I will cooperate to the best of my ability and knowledge with the child support enforcement agency while I am receiving MA/MCHP. Unless I am exempt or the State finds that I have good cause, I may lose all my benefits and my case may be closed if I do not cooperate with the child support enforcement agency. However, no child's case would be closed.

Third Party Payments And Cooperation With Quality Control Review I understand that I am required by law to assign to the State all rights to medical support and other third party payments (hospital and medical benefits) and to cooperate with the State's MA/MCHP quality control review process including verification of all information pertinent to the determination of eligibility.

Reporting Changes I have a responsibility to report all changes that might affect eligibility within ten (10) days of the change. Examples of changes I must report are changes in the number of people in the household, address, income, employment and pregnancy. I can report changes in person, by telephone, or by mail to my case manager at my local health department or local department of social services.

Fraud Every person convicted of "Medical Assistance Fraud" with a value of $500 or more in money, services or goods is guilty of a felony, and shall pay back money, services or goods; or the value of those services or goods unlawfully received. Be subject to a fine of no more than $10,000, imprisoned for no longer than five years, or both. Every person convicted of Medical Assistance Fraud" with a value of less than $500 or more in money, services or goods is guilty of a misdemeanor, and shall pay back money, services or goods; or the value of those services or goods unlawfully received. Be fined no more than $1,000 and imprisoned for no longer than three years, or both.

REMINDER: Before mailing, did you:

- **Sign and date the application?**
- **Include proof of citizenship and identity?**

LOCAL HEALTH DEPARTMENT

Allegany
Maryland Children's Health Program
12501 Willowbrook Rd.
P.O. Box 1745
S.E. Cumberland, MD 21502
(301) 759-5076
(301) 777-2097 FAX

Anne Arundel
County Department of Health
Maryland Children's Health Program
1 Harry S. Truman Pkwy.
Suite 200
Annapolis, MD 21401
(410) 222-4792
(410) 222-4391 FAX

Baltimore County
Baltimore County Health Department
MCHP Program
8501 LaSalle Rd.
Suite 103
Towson, MD 21286
(410) 887-2957
(410) 887-8095 FAX

Calvert
Maryland Children's Health Program
P.O. Box 980
Prince Frederick, MD 20678
(410) 535-5400
(301) 855-1353
(410) 535-1955 FAX

Caroline
Caroline County Health Department
P.O. Box 10 (Mail Only)
403 S. 7th Street
Denton, MD 21629
(410) 479-8004
(410) 479-0244 FAX

Carroll County Health Department
290 S. Center Street
P.O. Box 845
Westminster, MD 21158
(410) 876-4916
(410) 876-4905 FAX

Cecil
Maryland Children's Health Program
401 Bow Street
Elkton, MD 21921-5511
(410) 996-5126
(410) 996-5124 FAX

Charles Co.
Nursing & Community Health Services
P.O. Box 1050
White Plains, MD 20695-1050
(301) 609-6869/70/71/37
(301) 609-6899 FAX

Dorchester
Dorchester County Health Department
503-B Muir Street
Cambridge, MD 21613
(410) 228-3294
(410) 228-8976 FAX

Frederick
Frederick County Health Department
350 Montevue Lane
Frederick, MD 21702
(301) 600-1324 TEL
(301) 600-3111 FAX

Garrett
1025 Memorial Drive
Oakland, MD 21550
(301) 334-7720
(301) 334-7771 FAX

Harford
Maryland Children's Health Program
119 S. Hays St. P.O. Box 797
Bel Air, MD 21014
(443) 643-0343
(443) 643-0344 FAX

Howard County Health Department
7180 Columbia Gateway Drive
Columbia, MD 21046
(410) 313-7500
(410) 313-5838 FAX

Kent County Health Department
Maryland Children's Health Program
125 S. Lynchburg Street
Chestertown, MD 21620
(410) 778-7023
(410) 778-7019 FAX

Montgomery
Service Eligibility Unit
1335 Piccard Drive, Upper Level
Rockville, MD 20850
(240) 777-3120
(240) 777-1013 FAX

8630 Fenton Street, 10th floor
Silver Spring, MD 20910
(240) 777-3066
(240) 777-1307 FAX

12900 Middlebrook Road
Germantown, MD 20874
(240) 777-3591
(240) 777-3563 FAX

Prince George's
Maryland Children's Health Program
425 Brightseat Road, Suite 101
Landover, MD 20785
(888) 561-4049
(301) 324-2809 FAX

Queen Anne's
206 N. Commerce Street
Centreville, MD 21617
(410) 758-0720
(443) 262-9357 FAX

St. Mary's
MCHP Eligibility & Outreach
P.O. Box 316
21580 Peabody Street
Leonardtown, MD 20650-0316
(301) 475-4275
(301) 475-4350 FAX

Somerset
Somerset County Health Department
7920 Crisfield Highway
Westover, MD 21871
(443) 523-1700
(410) 651-2572 FAX

Talbot County Health Department
100 S. Hanson St.
Easton, MD 21601
(410) 819-5600
(410) 819-5691 FAX

Washington
Maryland Children's Health Program
(240) 313-3330
1302 Pennsylvania Avenue
Hagerstown, MD 21742
(240) 313-3334 FAX

Wicomico
Maryland Children's Health Program
(Mail Only)
108 E. Main Street
(In Person)
300 West Carroll St.
Salisbury, MD 21801
(410) 543-6944
(410) 543-6568 FAX

Worcester
Berlin Health Center
9730 Healthway Drive
Berlin, MD 21811
(410) 629-0164
(410) 957-2005
(410) 629-0185 FAX

Baltimore City
Baltimore Health Care Access MCHP
One Calvert Plaza
201 E. Baltimore Street
9th Floor
Baltimore, Md. 21202
(410) 649-0512
(410) 649-0533 FAX

REMINDER: Before mailing, did you:

- **Sign and date the application?**
- **Include proof of citizenship and identity?**

LOCAL DEPARTMENT OF SOCIAL SERVICES

BALTIMORE CITY DSS
Talmadge Branch Building (Walk In)
1910 N. Broadway
Baltimore, MD 21213
P.O. Box 17466 (Mail Only)
Baltimore, MD 21203-7466
443-423-6300
443-423-6501 FAX

ALLEGANY COUNTY DSS
1 Frederick Street
Cumberland, MD 21502
301-784-7000
301-784-7222 FAX

ANNE ARUNDEL COUNTY DSS
80 West St 2nd Floor Deck
Annapolis, MD 21401
410-269-4500
410-974-8566 FAX
Glen Burnie: 410-421-8550

BALTIMORE COUNTY DSS
6401 York Road
Towson, MD 21212
410-853-3000
410-853-3955 FAX
Catonsville: 410-853-3450
Dundalk: 410-853-3400
Essex: 410-853-3800
Reisterstown: 410-853-3010

CALVERT COUNTY DSS
200 Duke Street
Prince Frederick, MD 20678-0100
443-550-6900
410-286-7429 FAX

CAROLINE COUNTY DSS
300 Market Street
Denton, MD 21629
410-819-4500
410-819-4501 FAX

CARROLL COUNTY DSS
10 Distillery Drive
Westminster, MD 21157
410-386-3300
410-386-3429 FAX

CECIL COUNTY DSS
Elton District Court/ Multi-Service Building
170 E. Main Street
Elkton, MD 21921
410-996-0100
410-996-0464 FAX
Calls from Rising Sun: 410-658-2145

CHARLES COUNTY DSS
200 Kent Avenue
LaPlata, MD 20646
301-392-6400
301-870-3958 FAX

DORCHESTER COUNTY DSS
P.O. Box 217 (Mail Only)
627 Race Street (Walk In)
Cambridge, MD 21613
410-901-4100
410-901-1047 FAX

FREDERICK COUNTY DSS
P.O. Box 237 (Mail Only)
Frederick, MD 21705
100 E. All Saints Street (Walk In)
Frederick, MD 21701
301-600-4555
301-600-4550 FAX

GARRETT COUNTY DSS
12578 Garrett Highway
Oakland, MD 21550-0556
301-533-3000
301-334-5449 FAX

HARFORD COUNTY DSS
2 South Bond St
Bel Air, MD 21014
410-836-4700
410-836-4945 FAX
410-879-4500

HOWARD COUNTY DSS
7121 Columbia Gateway Dr.
Columbia MD, 21046
410-872-8700
410-872-4231

KENT COUNTY DSS
350 High Street
P.O. Box 670
Chestertown, MD 21620
410-810-7600
410-778-1497 FAX

MONTGOMERY COUNTY DHHS
1301 Piccard Drive, 2nd Floor
Rockville, Md 20850
240-777-4600
240-777-4100 FAX
Germantown:
240-777-3420
240-777-3477 FAX
Silver Spring:
240-777-3100
240-777-3070 FAX

PRINCE GEORGE'S COUNTY DSS
425 Brightseat Road
Landover, MD 20785
301-909-6000
301-909-6067 FAX
Hyattsville: 301-209-5000
301-209-5276 FAX
South County: 301-316-7700
301-316-7701 FAX

QUEEN ANNE'S COUNTY DSS
125 Comet Drive
Centreville, MD 21617
410-758-8000
410-758-8110 FAX

ST MARY'S COUNTY DSS
Joseph D. Carter Building
23110 Leonard Hall Drive
P.O. Box 509 (Mail Only)
Leonardtown, MD 20650
240-895-7000
240-895-7099 FAX

SOMERSET COUNTY DSS
P.O. Box 369 (Mail Only)
30397 Mt. Vernon Road
Princess Anne, MD 21853
410-677-4200
410-677-4300 FAX

TALBOT COUNTY DSS
301 Bay Street
P.O. Box 1479 (Mail Only)
Easton, MD 21601
410-770-4848
410-820-7117 FAX

WASHINGTON COUNTY. DSS
122 N. Potomac Street
P.O. Box 1419 (Mail Only)
Hagerstown, MD 21740
240-420-2100
240-420-2299 FAX

WICOMICO COUNTY DSS
201 Baptist Street, Suite 27
Salisbury, MD 21801
410-713-3900
410-713-3910 FAX

WORCESTER COUNTY DSS
299 Commerce Street
P.O. Box 39 (Mail Only)
Snow Hill, MD 21863
410-677-6800
410-677-6810 FAX

Print Form

Place Stamp Here

SEAL WITH TAPE HERE
DO NOT STAPLE

From: _____

_____

_____

TO: _____

_____
Street Address

_____
City State Zip Code