EMPLOYED INDIVIDUALS WITH DISABILITIES (EID) PROGRAM
APPLICANT/RECIPIENT CLAIM FOR HARDSHIP EXEMPTION
Eligibility Determination Division (EDD)
Schaefer Tower
6 St. Paul Street, Suite 400
Baltimore, Maryland 21202

Date_____

MA No._____

Name_____

Address_____

_____

Dear Eligibility Determination Division Case Manager,

I, _____ am requesting a review of my case for a "Claim of Hardship" (COMAR 10.09.41.07C.) for the exemption of paying my premium of $_____ for Medical Assistance (Medicaid) benefits under the Employed Individuals with Disabilities (EID) Program.

The reason I am requesting this is because:
(Please specifying the underlying circumstances payment of the enrollment fee would compromise your ability to obtain and provide basic food, shelter, and clothing. You may attach additional pages if needed.)

_____

_____

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_____

I expect the hardship to prevent me from paying my premium and/or prevents me from working for (circle one): 1 2 3 4 5 6 months. (Hardship cannot be granted for more than six months.) Please include documentation to verify expenses, income and resources for the months which a hardship is being requested.

Please list all sources of income you receive.

Monthly Income:

Social Security	$_____
Earnings (Before Taxes, Gross)	$_____
V.A.	$_____
Other _____	$_____
Other _____	$_____
Total Monthly Gross Income	$_____

Please complete the information for the following expenses.

Monthly Expenses:

Mortgage or Rent	$_____
Medical Expenses	$_____
Food	$_____
Electric or Gas	$_____
Total Monthly Expenses	$_____

_____ _____

Signature Date

The Department shall evaluate the claim of hardship and notify you of its decision within 30 days of the Department's receipt of the written claim of hardship. If the Department determines that the applicant or recipient's claim of hardship is without merit, the applicant or recipient shall pay the applicable premium within 10 days after the date the Department's notice is issued.