

# TRANSITIONAL BENEFIT REPORT

When completed, return this form to:

You **MUST** return this form no later than \_\_\_\_\_.

Use this form to report information or changes for these months:

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**If the address below is incorrect, please make changes.**



**How This Report Affects  
Your Transitional Benefits**



If you do not complete, sign, and return this form by the date shown above, your transitional benefits may be stopped.

What you report on this form may cause your Medicaid to stop.

**★ Do not complete or return this form until after the last day of the third month shown above. ★**

Please answer yes or no to the questions below. If you answer yes, complete the questions that follow. When completed, return this form to the address noted in the above left corner.

**1.** Did you or someone in your household receive money from **employment** during the three months listed above? **YES**  **NO**  If yes, provide income information for the three months. List each of the months.

*Month of* \_\_\_\_\_

| Who worked? | Employer | Dates Paid | Gross Amounts |
|-------------|----------|------------|---------------|
|             |          |            |               |
|             |          |            |               |
|             |          |            |               |

*Month of* \_\_\_\_\_

| Who worked? | Employer | Dates Paid | Gross Amounts |
|-------------|----------|------------|---------------|
|             |          |            |               |
|             |          |            |               |
|             |          |            |               |

*Month of* \_\_\_\_\_

| Who worked? | Employer | Dates Paid | Gross Amounts |
|-------------|----------|------------|---------------|
|             |          |            |               |
|             |          |            |               |
|             |          |            |               |

**Attach wage stubs if your income has changed from the last report.**

2. Did you or someone in your household have a **change in situation** during the three months? YES  NO  If yes, please answer the following questions:

A member of my household got new medical insurance or lost medical insurance. When? \_\_\_\_\_  
 Got new insurance? \_\_\_\_ or lost insurance? \_\_\_\_ Who? \_\_\_\_\_  
 Insurance company name: \_\_\_\_\_ Policy number: \_\_\_\_\_

Have there been other changes in situation such as a household member moving out or a baby born?  
 \_\_\_\_\_

3. Was a child in your household in day care so that someone in your household could work? YES  NO   
 \_\_\_\_\_ If you had child care expenses, please complete below. If  
 (Name of employed person) additional space is needed, please attach a sheet to this form.

Month of \_\_\_\_\_

| Name of Child(ren) | Dates Child Care Provided | Amounts You Paid For Child Care |
|--------------------|---------------------------|---------------------------------|
|                    |                           |                                 |
|                    |                           |                                 |
|                    |                           |                                 |

Month of \_\_\_\_\_

| Name of Child(ren) | Dates Child Care Provided | Amounts You Paid For Child Care |
|--------------------|---------------------------|---------------------------------|
|                    |                           |                                 |
|                    |                           |                                 |
|                    |                           |                                 |

Month of \_\_\_\_\_

| Name of Child(ren) | Dates Child Care Provided | Amounts You Paid For Child Care |
|--------------------|---------------------------|---------------------------------|
|                    |                           |                                 |
|                    |                           |                                 |
|                    |                           |                                 |

Signature of Child Care Provider \_\_\_\_\_ (name printed)

Address \_\_\_\_\_ Phone \_\_\_\_\_

**I certify that the information I have provided on this form is correct to the best of my knowledge.**

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Today's Date

\_\_\_\_\_  
 Home Phone Number

\_\_\_\_\_  
 Work Phone Number