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.

1. 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** ❒

_____
(Name of employed person)

If you had child care expenses, please complete below. If 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