2. If anyone in the household is an alien with a sponsor, write in the sponsor's name, income and resources.

3. IF SOMEONE IS WORKING, YOU MUST SEND IN PROOF OF HOW MUCH THAT PERSON MADE DURING THE REPORT PERIOD (include **ALL** pay stubs or other proof of income received during the period). If someone has other income, send in proof of the income. Photo-copies are allowed.

4. If someone in the household stopped working, stopped receiving income, or did not work in any of the previous three months, send in proof.

QUESTION 2
Did anyone move in or out of your household during the period (including births)?

☐ **NO** ☐ **YES** **If Yes,**

Write in any changes in the number of people in your household during the month such as: someone moved in or out, a parent returned home, someone is pregnant, a baby was born, etc., and send in proof of any change. Photo-copies are allowed.

NAMES	WHAT CHANGED	DATE OF CHANGE	OTHER INFORMATION

QUESTION 3
Did anything else change or do you expect any changes in your household during the next three months?

☐ **NO** ☐ **YES** **If Yes, explain on a separate sheet of paper.**

1. Answer this question for any other type of change, such as: marriage, moving, amount paid for child care, resources, or changes you think may happen in the future, or anything else your worker should know.

2. List the weekly amount spent on child care costs $ _____

3. List the amount of transitional child care reimbursement received $ _____

4. Do you have any other health care insurance coverage? ☐ YES ☐ NO
   If yes, list name of company and policy number.

   Insurance Company _____

   Policy Number _____

5. Send in proof of any change. Photo-copies are allowed.

WARNING: If this form is not returned, is late, or is incomplete, your Medicaid coverage may be delayed or discontinued. If you cannot complete or return the form on time, please contact your worker.

CERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including reducing the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am aware that Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the person is not entitled.

I understand that I must contact my worker immediately to report any change that occurs or if I have any doubt about needing to report any change.

Recipient's Signature:	Date:	Telephone Number With Area Code: Where You Can Be Reached

Fill out & Return in The Envelope Provided

When you return this Report, make sure you can see this address in the return envelope window ⟶