North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services EIS
1985 Umstead Drive – 2512 Mail Service Center - Raleigh, N.C. 27699-2512
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Nina M. Yeager, Director
(919) 857-4019

March 15, 2002

Re: Revised Transitional Medicaid Report

Dear County Director of Social Services:

The DMA-5082, Transitional Medicaid Report, mailed to recipients on the 25th of each month has been revised. Effective with reports mailed in March the attached revised report will not require recipients to answer questions regarding the receipt of child support payments. It is not a requirement that Transitional Medicaid recipients report the receipt of any type of unearned income.

Instructions for processing the report are found in Families and Children's Medicaid, MA-3405, Extended Medicaid for Working Families.

If you have questions, please contact your Medicaid Program Representative.

Sincerely,

Nina M. Yeager

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

1. If you do not complete, sign, and return this form by the date shown above, your transitional benefits may be stopped.
2. 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