State of Alaska
Department of Health and Social Services
Division of Public Assistance

INFORMATION ABOUT TRANSITIONAL MEDICAID

You have been notified that your Medicaid benefits changed from the Family Medicaid category to the Transitional Medicaid category. Transitional Medicaid may continue for up to 12 months after you became ineligible for Family Medicaid. The following are some important facts you need to know about Transitional Medicaid.

1. To get Transitional Medicaid for the first 6 months, you and your family must continue to meet all Medicaid rules. These include:

   a) having at least one child in your home who was included in your Family Medicaid case when it closed; AND
   b) remaining residents of Alaska; AND
   c) continuing to cooperate with the Child Support Enforcement Division (CSED).

2. To get the second 6 months of Transitional Medicaid, you and your family must continue to meet the same conditions above PLUS:

   a) you must complete and return a Transitional Medicaid Report form so that it gets to our office by the tenth day of the 4th, 7th, and 10th months of your Transitional Medicaid period, AND
   b) your family's countable earnings must be under the Transitional Medicaid income limit.

3. If you do not turn in the 4th month report, you and your family will only get the first 6 months of Transitional Medicaid. You will NOT get the second 6 months.

4. You cannot reapply for Transitional Medicaid once it closes. It is very important that you complete and turn in your report forms when they are due if you do not want to lose this Medicaid coverage.

5. You must also tell us by phone, mail, or in person within 10 days if you or a member of your family:

   a) move(s) out of your home;
   b) plan(s) to leave the State of Alaska; or
   c) get(s) or lose(s) any medical insurance.

IMPORTANT - IF YOUR INCOME AND/OR HOURS DECREASE, YOU MAY AGAIN BE ELIGIBLE FOR FAMILY MEDICAID. PLEASE CONTACT YOUR CASEWORKER FOR A REDETERMINATION OF FAMILY MEDICAID ELIGIBILITY.

INSTRUCTIONS FOR COMPLETING YOUR TRANSITIONAL MEDICAID REPORT FORM

You will receive a Transitional Medicaid Report form the month before it is due. Here is how to complete your report:

- Answer ALL questions.
- Sign and date the report.
- ATTACH PROOF of all family members' earnings and self-employment income for the 3 months before the month your report is due.
- ATTACH PROOF of all childcare costs, child support payments, and self-employment expenses for the 3 months before the month your report is due. If proof is not turned in, these expenses will not be deducted.

You will notice this report asks for 3 months of information. We suggest you list your family's earnings and expenses as they happen. Also you may want to use the envelope this letter came in to keep your family's paycheck stubs, self-employment, childcare receipts, and child support payments you make for the 3 months you are reporting.

This report is due in our office by the tenth day of the 4th, 7th, and 10th months of Transitional Medicaid coverage. We will send you a reminder notice the month before each report is due. This report is for Transitional Medicaid coverage ONLY.

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TRANSITIONAL MEDICAID REPORT

This report must be turned in to your Public Assistance office in the 4th, 7th, and 10th months of your Transitional Medicaid if you want this coverage to continue. You must report information from the three (3) months before the month this report is due.

Be sure to answer all questions completely. If the answer is "no" or "none", write "no" or "none". "N/A" is not an acceptable answer. Also, be sure to sign and date this report. Attach a separate sheet of paper if you need more space.

1. LIST ALL PERSONS WHO LIVE IN YOUR HOME. LIST YOURSELF FIRST.

NAME (Last, First, MI)	SOCIAL SECURITY NUMBER (SSN)	RELATION TO YOU	BIRTHDATE

2. Has anyone moved INTO or OUT OF your home in the last three months? ☐ Yes *(Provide details below)* ☐ No

Will anyone move INTO or OUT OF your home this month or in the next two months? ☐ Yes *(Provide details below)* ☐ No

The following person(s) ☐ moved IN ☐ moved OUT

Name of person _____ Relationship to you _____

The following person(s) will ☐ move IN ☐ move OUT

Name of person _____ Relationship to you _____

Is the person working? ☐ Yes ☐ No Is the person expected to start work? ☐ Yes ☐ No

3. Have you moved this month or in the last three months? ☐ Yes ☐ No

Do you plan to move? ☐ Yes ☐ No Date of planned move: _____

What is or will be your new mailing address? _____

What is or will be your new home address? _____

4. Your daytime telephone number: _____ Message telephone number: _____

5. Do you or any members of your family have any type of medical insurance through employment, a spouse, ex-spouse, or parent, etc.?

☐ Yes *(Provide details on next page)* ☐ No

Name(s) of person(s) covered:	Name(s) of person(s) covered:
Name, SSN, and employer of insured person:	Name, SSN, and employer of insured person:
Name and address of insurance company:	Name and address of insurance company:
Policy or claim number: _____ Group number: _____ Start date: _____ Stop date: _____ Type of coverage (hospital, dental, vision, etc.): _____	Policy or claim number: _____ Group number: _____ Start date: _____ Stop date: _____ Type of coverage (hospital, dental, vision, etc.): _____

6. Was anyone injured and/or involved in an accident in the last three months? ☐ Yes ☐ No

If yes, please attach a separate sheet explaining who was involved, what happened, and the name of any other insurance carrier who may be paying a settlement and/or medical bills.

7. Have you, or has anyone in your family who lives with you, stopped or started working or had any other change in earnings?

☐ Yes ☐ No If yes, give name, date, and what happened: _____

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8. INCOME: REPORT ALL EARNINGS you, or anyone in your family who lives with you, received in the last three months. List the date and amount of all earnings received in each month. List the GROSS income before any deductions.

a) Here are some examples of what you should report: money from work, pay advances, room and board, baby-sitting, odd jobs, fishing, trapping, National Guard, handicrafts, taxi driving, and door-to-door sales.

b) Self-employed person: enter income before expenses and attach a separate sheet of paper listing the monthly expenses.

ATTACH PROOF OF EARNINGS (such as a statement from your employer, pay stubs, fish tickets, expense receipts, or self-employment ledgers)

ATTACH PROOF OF CHILDCARE COSTS (only work-related childcare costs are deducted from income)

ATTACH PROOF OF CHILD SUPPORT PAYMENTS (paid to a child living in another household)

	Person Receiving Income	Gross Income Amount	Tips	Date Received	Employer's Name and Phone No.	Child Care Paid (While Working)	For Which Children?	Child Support Payments Made	Who Pays?
MONTH #1		$	$		$	$		$	
		$	$		$	$		$	
		$	$		$	$		$	
		$	$		$	$		$	
		$	$		$	$		$	

	Person Receiving Income	Gross Income Amount	Tips	Date Received	Employer's Name and Phone No.	Child Care Paid (While Working)	For Which Children?	Child Support Payments Made	Who Pays?
MONTH #2		$	$			$		$	
		$	$			$		$	
		$	$			$		$	
		$	$			$		$	
		$	$			$		$	

	Person Receiving Income	Gross Income Amount	Tips	Date Received	Employer's Name and Phone No.	Child Care Paid (While Working)	For Which Children?	Child Support Payments Made	Who Pays?
MONTH #3		$	$			$		$	
		$	$			$		$	
		$	$			$		$	
		$	$			$		$	
		$	$			$		$	

I understand that the information I provide on this report may result in changes in my family's Medicaid coverage or my Transitional Medicaid case being closed. Under penalty of unsworn falsification, I certify that the information on this report is correct, accurate, and complete to the best of my knowledge. I understand that this information may be investigated and verified by federal, state, and local officials.

I understand my Transitional Medicaid case may be closed or my benefits delayed if I do not submit proof of income and other proof that is required with this report. I understand that self-employment or child care expenses cannot be deducted if I have not sent in proof with this form.

I understand that if I disagree with any action taken by the Division of Public Assistance that affects my eligibility for Transitional Medicaid, I have the right to request a fair hearing.

X _____ _____

SIGN HERE DATE SIGNED