Georgia Department of Human Services
Division of Family and Children Services
Transitional Medical Assistance Quarterly Report Form

Name _____ **Case #** _____

Case Worker Name _____ **Case Worker Phone #** _____

Date _____

Your caseworker must receive this form by _____ .

Failure to return this form could result in closure of your Medicaid case.
Complete each section below and provide proof of income. Please provide one of the following:

- Pay stubs for all months listed, OR
- Have the employer sign and complete the earnings section, OR
- Get a signed statement from the employer including all the information listed.

Bring or mail this form and proof of income to the county office. If you need help completing this form, contact the county office.

COMPLETE EACH SECTION BELOW ABOUT THE MONTHS OF

_____ **THROUGH** _____ .

1.
2. Did someone move in or out of your home?

_____ Yes _____ No ***If yes, complete the section below.***

Name	Relationship	Date of Birth	Social Security Number	Month Moved	
				In	Out

3. Did you or anyone else in your Medicaid case work in the months listed above?

_____ Yes _____ No ***If yes, please complete the questions on the next page.***

Name of person who worked: ______________________________

Employer: ______________________________

Name of person who paid childcare: ______________________________

Childcare provider: ______________________________

Is the person who worked a full-time student? ________ Yes ________ No

If yes, name of the school: ______________________________

Month of:

Earnings		
Date Paid	Gross Pay	Tips

Childcare Costs	
Date Paid	Amount

Month of:

Earnings		
Date Paid	Gross Pay	Tips

Childcare Costs	
Date Paid	Amount

Month of:

Earnings		
Date Paid	Gross Pay	Tips

Childcare Costs	
Date Paid	Amount

Employer Signature ______________________________

Employer Phone Number ______________________________

I understand that:

- Information on this report form may stop my Medicaid.
- I must continue to report any changes in my situation within 10 days of knowing about the change.
- If I do not return this report form by the due date, and provide proof where required, my Medicaid may stop.
- If I do not tell the truth, I may be prosecuted for fraud.

Your Signature or Mark	Date	Phone Number
Signature of Person Helping to Complete Form	Date	Phone Number