Return this form to: Manager 3 Team A ESO
PO BOX 143245
SALT LAKE CITY, UT 84114-3245

MEDICAID QUARTERLY REPORT

Utah-DOH-BES
Form 632-T revised 08/11 - eREP BIRT

Name: AVERY ALEXANDRIA DEGERING
Mailing Address:
748 WYMOUNT TER
PROVO, UT 84604-2057

Return this form to: Manager 3 Team A ESO
PO BOX 143245
SALT LAKE CITY, UT 84114-3245

If address or phone number has changed, cross out old information and write in new address and phone number. Please provide us with verification of your new address.

Case Number: 17895199

Your report must be completed by the 17th of July.
You may call 801-526-0950 for help with this form.

You must verify all earnings for the 3 months listed below by the 17th of next month:

Month 1: April **Month 2:** May **Month 3:** June

- We need this information to see if you are still eligible for the Twelve Month Transitional Medicaid program.
- You may also list any paid child care expenses, which may reduce the countable income.
- **If we do not receive this information by the 17th of next month, YOUR MEDICAL CASE WILL BE CLOSED.**

I **HOUSEHOLD COMPOSITION**

Has anyone moved in or out of your household since your last report?... YES ☐ NO ☐
If yes, please explain

II **HEALTH INSURANCE CHANGES**

Has there been any changes in your health insurance coverage?... YES ☐ NO ☐
If yes, please explain

III **EARNED INCOME AND EXPENSES**

1. Complete the information below and **verify** the income by providing copies of pay checks.
2. If you do not have earned income in any of the three months, you must explain why.
3. List any **paid** child care expenses for each child seperately. (Example: Billy $75, Ann $100)

Name of Employed Person #1	**Name of Employed Person #2**
Month ______________ Child Care Expenses	**Month ______________ Child Care Expenses**
Check Date___________ Amount $	Check Date___________ Amount $
Check Date___________ Amount $	Check Date___________ Amount $
Check Date___________ Amount $	Check Date___________ Amount $
Check Date___________ Amount $	Check Date___________ Amount $
Month ______________ Child Care Expenses	**Month ______________ Child Care Expenses**
Check Date___________ Amount $	Check Date___________ Amount $
Check Date___________ Amount $	Check Date___________ Amount $
Check Date___________ Amount $	Check Date___________ Amount $
Check Date___________ Amount $	Check Date___________ Amount $
Month ______________ Child Care Expenses	**Month ______________ Child Care Expenses**
Check Date___________ Amount $	Check Date___________ Amount $
Check Date___________ Amount $	Check Date___________ Amount $
Check Date___________ Amount $	Check Date___________ Amount $
Check Date___________ Amount $	Check Date___________ Amount $

UTAH-DOH-BES
FORM 632T NOTICE
NOTICE FOR 2ND AND 3RD REPORT PERIODS

IMPORTANT NOTICE CONCERNING YOUR BENEFITS

You are currently receiving Twelve Month Transitional Medicaid. In order to continue receiving Medicaid under this program, you must verify your earnings for the months listed on the other side of this notice. We must have this information by the 17th of next month or your Medicaid case will be closed.

EXAMPLE: For a report mailed on June 22, you would need to verify your income for April, May, and June. The verifications must be turned in by the 17th day of July. If the verifications are not returned by July 17th, your medical assistance would be closed at the end of July.

Please complete the form on the other side of this notice and return it along with the verification of your earnings to the return address printed on the form.

You will receive a full twelve months of Medicaid coverage under the Twelve Month Transitional Medicaid program, as long as you meet all of the following requirements:

A. You continue to have a dependent child in your home.
B. You continue to reside in the state of Utah.
C. You comply with the income reporting requirements.
D. You have earnings or have good cause for no earnings in each month of the three report periods.
E. Your average countable earnings do not exceed the income limit for your household size in the second and third rep periods. (185% of the Federal Poverty Limit)

If you have any questions about your case, contact us at the phone number listed at the top of the report form.

You are only required to verify your income for Transitional Medicaid; however, please remember that you are still required by law to report changes in your situation within 10 days of the day you learn of the change. Do not delay reporting changes. Changes can affect the amount of our benefits or your eligibility. If you receive more than you are eligible to receive, you will have to repay that amount.