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	NO	YES	If Yes,					
SESTION 3 Tanything else change or do you expect any changes in your household during the next three months?	Write paren	in any chang it returned hoi	es in the nu					
d anything else change or do you expect any changes in your household during the next three months? NO		NAMES			WHAT CHANGED	DATE OF C	HANGE	OTHER INFORMATION
d 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, 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 \$								
darything 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, 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 \$								
d 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, 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 \$								
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, 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 \$								
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, 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 \$	JESTION	N 3						
1. Answer this question for any other type of change, such as: marriage, moving, amount paid for child care, resources, 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 \$		ing else change				ng the next three mo	nths?	
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 \$	NO	YES	If Yes, exp	olain on a sepa	arate sheet of paper.			
2. List the weekly amount spent on child care costs \$								aid for child care, resource
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. VARNING: If this form is not returned, is late, or is incomplete, your Medicaid coverage may be delayed or discontinued. If you annot complete or return the form on time, please contact your worker. EERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am away hat Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the reson 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 report any change. Recipient's Signature: Date: Telephone Number With Area Code:	2. Lis	at the weekly a	mount spen	t on child car	e costs \$			
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 Po		_	•					
If yes, list name of company and policy number. Insurance Company								
Policy Number 5. Send in proof of any change. Photo-copies are allowed. VARNING: If this form is not returned, is late, or is incomplete, your Medicaid coverage may be delayed or discontinued. If you annot complete or return the form on time, please contact your worker. EERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including educing the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am awant at Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the erson 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 report any change. Recipient's Signature: Date: Telephone Number With Area Code:					3	YES NO		
5. Send in proof of any change. Photo-copies are allowed. VARNING: If this form is not returned, is late, or is incomplete, your Medicaid coverage may be delayed or discontinued. If you annot complete or return the form on time, please contact your worker. EERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including educing the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am awant Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the erson 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 report any change. Recipient's Signature: Date: Telephone Number With Area Code:	Ins	surance Comp	any					
5. Send in proof of any change. Photo-copies are allowed. VARNING: If this form is not returned, is late, or is incomplete, your Medicaid coverage may be delayed or discontinued. If you annot complete or return the form on time, please contact your worker. EERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including educing the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am awantat Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the erson 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 report any change. Recipient's Signature: Date: Telephone Number With Area Code:	Po	licy Number						
VARNING: If this form is not returned, is late, or is incomplete, your Medicaid coverage may be delayed or discontinued. If you annot complete or return the form on time, please contact your worker. EERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including educing the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am awa nat Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the erson 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 report any change. Recipient's Signature: Date: Telephone Number With Area Code:		-						
ERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including ducing the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am awa nat Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the erson 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 report any change. Recipient's Signature: Date: Telephone Number With Area Code:	0. 00	ila ili proor or	iny change.	i noto-copie	s are anowed.			
ERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including ducing the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am awa nat Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the erson 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 report any change. Recipient's Signature: Date: Telephone Number With Area Code:	/ARNIN	NG: If this for	n is not ret	urned. is late	e. or is incomplete. vour l	Medicaid coverage	mav be	delaved or discontinued. If
educing the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am awant Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the erson 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 report any change. Recipient's Signature: Date: Telephone Number With Area Code:						Ū	,	•
report any change. Recipient's Signature: Date: Telephone Number With Area Code:	ERTIF	FICATION: I	understand	that the info	ormation I provide on this	report may result	in chang	ges in my assistance, inclu
I understand that I must contact my worker immediately to report any change that occurs or if I have any doubt about needing report any change. Recipient's Signature: Date: Telephone Number With Area Code:								
Recipient's Signature: Date: Telephone Number With Area Code:			Laws plov	ide for filles	and/or imprisonment or a	ny person who had	addientry	receives medicald to willen
Recipient's Signature: Date: Telephone Number With Area Code:	lur	nderstand that	I must conf	tact mv work	er immediately to report a	ny change that occ	curs or if	I have any doubt about need
				,	· · · · · · · · · · · · · · · · · ·	,		
· · · · · · · · · · · · · · · · · · ·								
Where You Can Be Reached	Recipien	nt's Signature:			Date:	Telepho	ne Numbe	er With Area Code:
						Where	You Can E	Be Reached

LDSS-4151 (Rev. 3/04) XL037B (3/04)

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