

TO: ☐ Work First ☐ MA ☐ FNS ☐ Child Support ☐ Program Integrity ☐ Services ☐ Child Care

FROM: \_\_\_\_\_ DATE: \_\_\_\_\_

## INCOME MAINTENANCE TRANSMITTAL FORM

### I. GENERAL INFORMATION

County Case No. \_\_\_\_\_ EIS/FSIS Case ID \_\_\_\_\_

IV-D Case No. \_\_\_\_\_ SIS ID No \_\_\_\_\_

Payee/Case Name: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Address: \_\_\_\_\_

Change of Address: ☐ No ☐ Yes - ☐ mailing ☐ residence

Family Unit Members

Non-Family Unit Members

Absent Parent Name: \_\_\_\_\_ ID No. \_\_\_\_\_

Absent Parent Name: \_\_\_\_\_ ID No. \_\_\_\_\_

Third Party Insurance: ☐ Yes ☐ No If yes, complete the following:

Name of Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Person Covered: \_\_\_\_\_

### II. BENEFIT INFORMATION

☐ FNS ☐ MA ☐ Work First – Payment type 1 ☐ Payment type 2 ☐

BENEFITS HAVE BEEN: ☐ Reviewed ☐ Revised ☐ Approved ☐ Denied/Term.

☐ Payment type 1 transferred to payment type S ☐ Payment type 2 transferred to payment type S

☐ MA Case Pending Deductible ☐ MA Case No Deductible

Date: \_\_\_\_\_ Benefit Amt. \_\_\_\_\_ Certified from \_\_\_\_\_ to \_\_\_\_\_

Benefit Amt. from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ 1<sup>st</sup> Mo. Benefit \$ \_\_\_\_\_ Authorized from \_\_\_\_\_ to \_\_\_\_\_

Eff. Date \_\_\_\_\_ Approx. Date Rec'd \_\_\_\_\_ Deductible \$ \_\_\_\_\_ Ongoing Benefit \$ \_\_\_\_\_

☐ Denied/Term. Effective Date \_\_\_\_\_

Reason for change: \_\_\_\_\_

Review Period: From \_\_\_\_\_ To \_\_\_\_\_

CHILD CARE: Type of Child Care Payment: ☐ Direct ☐ Vendor

Eff. Date: \_\_\_\_\_ Actual Costs \$ \_\_\_\_\_ Amt. Paid \$ \_\_\_\_\_

### WORK FIRST PENALTY/SANCTION:

Reason for WORK FIRST penalty/sanction - noncompliance with: ☐ MRA ☐ Child Support ☐ Substance Abuse Treatment

MRA noncompliance reason: \_\_\_\_\_

☐ Other reason \_\_\_\_\_

### III. INCOME VERIFICATION (EARNED AND UNEARNED)

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Employer/Source: \_\_\_\_\_ Employer/Source: \_\_\_\_\_

Amt: \$ \_\_\_\_\_ Date Rec'd: \_\_\_\_\_ Amt: \$ \_\_\_\_\_ Date Rec'd: \_\_\_\_\_

Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_

Start Date: \_\_\_\_\_ Term. Date: \_\_\_\_\_ Start Date: \_\_\_\_\_ Term. Date: \_\_\_\_\_

### IV. OTHER

#### Service Requests:

☐ Assistance with scheduling appointment Date Requested \_\_\_\_\_

☐ Assistance with transportation Date Requested \_\_\_\_\_

☐ Health Check for: \_\_\_\_\_ Date Requested \_\_\_\_\_

☐ Family Planning requested for: \_\_\_\_\_

☐ Other: \_\_\_\_\_ for: \_\_\_\_\_

☐ Other reported Change/Information: (Such as change in household composition, reserve, good cause claim, change in absent parent information, etc.) \_\_\_\_\_