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 $_____ 1st 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.) _____

_____