TRANSITIONAL MEDI-CAL (TMC)
QUARTERLY STATUS REPORT

This status report is for the months of			Return this form no later than the 21st day of
Month 1	Month 2	Month 3	

IMPORTANT: COMPLETE, SIGN, AND RETURN THIS REPORT TO THE WELFARE DEPARTMENT IN THE ENCLOSED ENVELOPE. Attach proof of your income, actual child care expenses paid, and total hours of employment for the three months noted above. If you have any questions regarding this form or the items to be reported, contact your eligibility worker.

- **For Transitional Medi-Cal (TMC)**—You will receive status reports during this period. If you do not complete and return these reports, your eligibility for TMC will be discontinued.

PART A. DISCONTINUANCE REQUEST

I request that my ***Transitional Medi-Cal*** be stopped on the last day of _____
Month/Year

I know that I can reapply for ***Medi-Cal*** at any time. _____ _____
Applicant signature Date

IF YOU WANT YOUR TMC ELIGIBILITY TO CONTINUE, PLEASE COMPLETE AND SIGN PART B OF THIS REPORT.

PART B. ELIGIBILITY STATUS INFORMATION

1. Did anyone receive any income, money, or benefits during the report period such as salary, wages, tips, commissions, bonuses, vacation pay? **If yes, attach proof (all pay stubs) for each report month.** ❒ Yes ❒ No

Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
	Total hours worked:			
	Income received?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
	Total hours worked:			
	Income received?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
	Total hours worked:			
	Income received?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
	Total hours worked:			

2. Did you or any family member receive money or benefits from other sources such as disability, unemployment, child support, or social security? **If yes, attach proof (all pay stubs) for each report month.** ❒ Yes ❒ No

Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
	Income received?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
	Income received?	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No

3. a. Did you or any family member **receive free** housing, utilities, food, or clothing in the report month? ❒ Yes ❒ No
   b. Did you or any family member **work for** housing, utilities, food, or clothing in the report month? ❒ Yes ❒ No

If yes to 3a and 3b, you must answer the three questions on the next line.

(1) What was received?	(2) Who received it?	(3) Who provided it?

4. Did you or anyone pay for child care expenses which have not or will not be reimbursed? ❒ Yes ❒ No
   If yes, complete the following:

Name of Child(ren)	Age	Amount Paid for Child Care Expenses			Name of Child Care Provider
		Month 1	Month 2	Month 3	

5. Did you have changes in your family or household during the time specified? (Include change of address, change of child care provider, change of employment, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) ❒ Yes ❒ No
   If yes, complete the following:

Name	Relationship	What Happened	Date

6. a. Do you or anyone have or expect to receive private health, vision, or dental insurance? (This includes insurance paid by an absent parent.) ❒ Yes ❒ No
   b. Do you have or expect to receive health insurance through your employer? ❒ Yes ❒ No
   c. Does your employer offer health insurance for a monthly premium? ❒ Yes ❒ No
   If yes, complete the following:

Name of Insurance	Person(s) Insured

CERTIFICATION

I understand that reported facts may result in benefits being changed or stopped.

I understand that the statements I have made on this form are subject to investigation and verification.

I understand that I must notify my worker within ten days of any change.

I understand that failing to report facts or giving wrong or incomplete facts can result in legal prosecution with penalties of a fine, imprisonment, or both.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES AND THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUE AND CORRECT AND IS COMPLETE FOR THE ENTIRE REPORT PERIOD.

Signature or mark of applicant	Date	Phone number
		( )
Signature of witness to mark, interpreter, or other person	Date	Phone number
		( )