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| **Form M: Interim Recertification Worksheet** |
| ***Must be completed if the household has experienced a change in income, residency, and/or composition and will remain in the program.*** |
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| **Change in Household Income** |
|  |  |  |  |  |
| HAS THE HOUSEHOLD EXPERIENCED A CHANGE IN INCOME OF $200 OR MORE PER MONTH?  | [ ]  | Yes | [ ]  | No |
|  |  |  |  |  |
| If *yes*, did household income increase or decrease? |[ ]  Increase | [ ]  | Decrease |
|  |  |  |  |
| If *yes*, date of change:  |       |  |
|  |  |  |
|  |  | *Household Member* | *Income Source* | *Gross: Last 30 Days* | *Pay Frequency* | *Date of Receipt* |
|  | Income change 1: |       |
|  |  |  |  |  |
|  | Income change 2: |       |
|  |  |  |  |  |
|  | Income change 3: |       |
|  |  |  |  |  |
|  |  |  |  |  |
| Is household annual gross income still under 80% of AMI per household’s county of residence? | [ ]  | Yes | [ ]  | No |
| *Attach documentation of change in income (documentation must be complete and cover the 30 days preceding the recertification date). If household annual gross income exceeds 80% of AMI, household is no longer eligible for the program. Complete and attach Form I for TBRA or TSH households and Form C for all households.* |
|  |
| **Change in Address** |
|  |  |  |  |  |
| HAS THE HOUSEHOLD EXPERIENCED A CHANGE IN RESIDENCY?  | [ ]  | Yes | [ ]  | No |
|  |  |  |  |
| If *yes*, date of change:  |       |  |
|  |  |  |
|  |  |  |
|  | New address: |       |
|  |  | *Street and Unit, City, State, Zip, County* |
|  |  |  |  |  |
| Does household still reside in the provider’s Public Health Region?  | [ ]  | Yes | [ ]  | No |
|  |  |  |  |  |
| Is household annual gross income still under 80% of AMI per household’s county of residence? | [ ]  | Yes | [ ]  | No |
| *Attach documentation of change in residency (documentation must be current as of the recertification date). If household is outside of the provider’s SDA, program services will end immediately and household may seek services from the provider in their new SDA. If household annual gross income exceeds 80% of AMI, household is no longer eligible for the program. Complete and attach Forms H and I for TBRA or TSH households and Forms C and G for all households.* |
|  |
| **Change in Household Composition** |
|  |  |  |  |  |
| HAS THE HOUSEHOLD EXPERIENCED A CHANGE IN COMPOSITION?  | [ ]  | Yes | [ ]  | No |
|  |  |  |  |
| If *yes*, did the number of household members increase or decrease? | [ ]  | Increase | [ ]  | Decrease |
|  |  |  |  |
| If *yes*, date of change:  |       |  |
|  |  |  |
|  |  |  |
| Household member: |       | [ ]  | Joined | [ ]  | Left |
|  |  |  |  |  |  |
| Household member: |       | [ ]  | Joined | [ ]  | Left |
|  |  |  |  |  |  |
| Household member: |       | [ ]  | Joined | [ ]  | Left |
|  |  |  |  |  |  |
|  |  |  |  |  |
| Does household still include an eligible individual? | [ ]  | Yes |[ ]  No |
|  |  |  |  |  |
| Is household annual gross income still under 80% of AMI per household’s county of residence? | [ ]  | Yes | [ ]  | No |
| *Attach eligibility documents for all new household members 18 years of age and older. If household does not include an eligible individual, household is no longer eligible for the program unless household qualifies for the provider’s grace period. If household annual gross income exceeds 80% of AMI, household is no longer eligible for the program. Complete and attach Forms C and E: Additional Beneficiaries data.* |
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| **I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the Program and may be grounds for termination of assistance.**  |
|  |  |  |  |
| Client/Household Member Name: |       |  |  |
|  |  |  |  |
| Client/Household Member Signature: |       | Date: |       |
|  |  |  |  |
|  |  |  |  |
| Case Manager Name: |       |  |  |
|  |  |  |  |
| Case Manager Signature: |       | Date: |       |