

**EARNED INCOME STATEMENT FOR PREMIUM**



Dear \_\_\_\_\_ :

Premiums for Medicaid for Employed People with Disabilities (MEPD) are based on average gross monthly income expected to be received each month for a six month period. It is time to make a new determination for your premium amount for your next six month premium period.

For us to make a new determination of your next premium amount, you must complete and return this form with verification of your income by \_\_\_\_\_. If you do not, your benefits may stop or be delayed. Verification of earned income would be pay stubs for each payday or an employer’s statement that is signed and dated by the employer, that lists the gross income paid to you for each pay period.

If you do not have earned income from employment or self-employment, please tell us when earned income stopped. My earned income stopped \_\_\_\_\_.

Use extra paper, if needed, for your answers.

<b>Gross earned income from work for the last 30 days:</b> Earned income is such things as wages, tips, commissions, bonuses or work study.					
Name of Employer _____			Name of Employer _____		
	Date Paid (Payday)	Gross Amount		Date Paid (Payday)	Gross Amount
1st paycheck			1st paycheck		
2nd paycheck			2nd paycheck		
3rd paycheck			3rd paycheck		
4th paycheck			4th paycheck		
5th paycheck			5th paycheck		
It is a good idea to write your name and the date on each pay stub.					

If your earned income is from self-employment, send in a copy of your most recent income tax forms. If you did not file income tax forms, then supply your worker with your self-employment records.

**You must sign and date this form. See next page.**

**Unearned income:** Unearned income is such things as Social Security, SSI, veterans, child support, unemployment, disability, educational grants and loans, cash gifts, or other income (explain).  
Send proof of this income if the income is new, has changed or stopped.

Source	Amount	Dates Received

Check the box below that applies to your information.

- The income information I am sending correctly represents my usual monthly earned and unearned gross income. I do not expect the amount to change in the next six month premium period.
- The income information I am sending does not correctly represent my usual monthly gross earned and unearned income. If you have checked this box, please explain below what the change will be. Provide signed and dated verification from the source of the income that tells how much your monthly income is expected to be and the date the change is expected to occur.

\_\_\_\_\_

\_\_\_\_\_

Report any change that could affect your eligibility within 10 calendar days of the change. Examples of changes you need to report include changes in your gross unearned or earned income, changes in resources such as cars, motorcycles, trucks, bank accounts, property, health insurance, etc.

Please call \_\_\_\_\_ at \_\_\_\_\_ if you have questions regarding this form.

<b>Signature and date: READ THESE STATEMENTS CAREFULLY BEFORE YOU SIGN.</b>		
<ul style="list-style-type: none"> <li>◆ I know what I reported here. I believe it is true, correct, and complete.</li> <li>◆ I agree to allow Government Quality Control reviewers to check my answers with other people.</li> <li>◆ I know what I reported may cause my premium to be reduced or increased.</li> <li>◆ I know I have to repay benefits I get incorrectly.</li> <li>◆ I know you may call the person who witnessed my mark or helped me complete this report.</li> </ul>		
<b>Sign and date below.</b>		
Signature	Month/Day/Year	Phone Number
Witness to mark or person who helped complete the report	Month/Day/Year	Phone Number