South Carolina Department of Health and Human Services
TRANSITIONAL MEDICAID WORKSHEET

Case Name: _____ Budget Group Number: _____

Section 1 **Gross Earned Income** Parent/Caretaker Relative	**Section 2** **Gross Earned Income** Parent/Caretaker Relative
Name:	Name:
1. 1st week $_____ 2. 2nd week $_____ 3. 3rd week $_____ 4. 4th week $_____ 5. Total $_____ 6. Avg. Pay. Amt. $_____ 7. Avg. Mo. Amt. $_____	1. 1st week $_____ 2. 2nd week $_____ 3. 3rd week $_____ 4. 4th week $_____ 5. Total $_____ 6. Avg. Pay. Amt. $_____ 7. Avg. Mo. Amt. $_____

Section 3
Actual Child Care Expense

1. Actual amount charged for child care for children under age 12 in the budget group: $_____
2. Amount of child care paid by ABC Child Care Voucher: $_____
3. Subtract the amount in Section 3, line 2 from the amount in Section 3, line 1, and write the difference here: $_____
4. Number of children for whom caretaker pays for care: _____
5. Multiply the amount in Section 3, line 4 x $200, and write the result here: $_____

Section 4
Eligibility Determination

1. Add amounts in Section 1, line 7 and Section 2, line 7, and write the total here: $_____
2. Write here the amount in Section 3, line 3 or the amount in Section 3, line 5, whichever is smaller: $_____
3. Subtract Section 4, line 2 from Section 4, line 1, and write the difference here: $_____
4. 185% of poverty: $_____

If the amount on line 3 of Section 4 is greater than or equal to the amount on line 4 of Section 4, the family is not eligible for continued Transitional Medicaid.

Section 5
Decision

☐ Continue eligibility
☐ Terminate eligibility Effective Date of Termination: _____

Signature of Eligibility Worker: _____ Date: _____