



Case Number: [Added by staff]  
Primary Applicant: [Added by staff]

We have received your application however we need some more information from you. Fill out this form and return it to us by **[10 DAYS FROM MAILING]**.

You have told us that [INSERT NAME] is claimed as a tax dependent by [NAME/YOUR MOTHER/SOMEONE ELSE]. We need to know more information about this person and all other people listed on that tax return. Look at page 2 for more instructions.

Name of Person completing form: \_\_\_\_\_

Date: \_\_\_\_\_

If you need assistance in completing this form, call us at 1-800-792-4884.

	Name	Date of Birth	SSN*	Relationship to [INSERT CASE NAME]	Does this person have income? If yes, send proof	If yes, what type? Examples: Wages, Social Security, Unemployment Compensation	What is the monthly amount of income?
<b>Tax Filer #1</b>	[INSERT TAX FILER NAME]	/ /			<input type="checkbox"/> No <input type="checkbox"/> Yes		\$
<b>Tax Filer #2 If filing jointly</b>		/ /			<input type="checkbox"/> No <input type="checkbox"/> Yes		\$
<b>Dependent</b>		/ /			<input type="checkbox"/> No <input type="checkbox"/> Yes		\$
<b>Dependent</b>		/ /			<input type="checkbox"/> No <input type="checkbox"/> Yes		\$
<b>Dependent</b>		/ /			<input type="checkbox"/> No <input type="checkbox"/> Yes		\$
<b>Dependent</b>		/ /			<input type="checkbox"/> No <input type="checkbox"/> Yes		\$
<b>Dependent</b>		/ /			<input type="checkbox"/> No <input type="checkbox"/> Yes		\$

\*We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with medical assistance. If someone doesn't have a SSN, call 1-800-772-1213 or visit [www.socialsecurity.gov](http://www.socialsecurity.gov)

