



Six Month Recertification Review Form

Required Form

To be completed by Eligibility staff to document applicant's re-determination.

Re-determination Date Eligibility Staff Name

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|--|--|
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|--|--|

Client's Name Address

| | |
|--|--|
| | |
|--|--|

Please indicate any changes that have occurred and attach appropriate documentation:

Change No Change

| | | |
|--|--------------------------|--------------------------|
| Living in Florida | <input type="checkbox"/> | <input type="checkbox"/> |
| Participating in Other Social Service Programs | <input type="checkbox"/> | <input type="checkbox"/> |
| Income | <input type="checkbox"/> | <input type="checkbox"/> |

The client has provided updated documentation for any items marked "change" and/or updated income information where necessary. ** All employment income must be verified every six months.

Fill in the following information based on the re-determination.

| | |
|--------------------------------------|--|
| Household Size | |
| FPL | |
| Income | |
| Other Programs (list all that apply) | |

Eligibility Staff Printed: _____

Eligibility Staff Signature: _____

Date: _____