Instructions: MO HealthNet Application

CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. We keep your information private and secure, as required by law. We'll use your information only to see if you qualify for MO HealthNet (Medicaid).

Complete this application if you want MO HealthNet (Medicaid) to cover medical expenses including Nursing Home Care or if you need assistance paying your Medicare health insurance premiums. You can apply for yourself and/or immediate family members living with you.

IF YOU NEED HELP COMPLETING THIS APPLICATION, call us at 1-855-373-4636.

If you need help in a language other than English, call 1-855-373-4636 and tell the customer service representative the language you need. TTY users can call 1-800-735-2966.

If you are blind or visually impaired and would like information regarding Rehabilitation for the Blind, please call 1-800-592-6004.

All applicants must complete Sections 1 - 7

Section 1: Your Information

Applicant Name Full legal name, include maiden name (legal name before marriage), if this applies to the person.

Address/Phone Number(s) We need to be able to contact the people applying for health insurance. The home address is where the people applying for health insurance live. The mailing address, if different, is where you want us to send MO HealthNet cards and notices about your case.

Social Security Number A Social Security Number should be provided for all persons applying, if the person has one. If the person does not have a Social Security Number, leave this box blank. *(**NOTE:** Social Security numbers do not have to be given; however, if social security numbers are NOT given for the persons applying for coverage, the application cannot be approved.)*

Date and Place of Birth Include city and state of birth. If born outside of the United States, write the country of birth.

Race/Ethnic Group This information is optional, but it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes your race or ethnic background. You may pick more than one.

Check List: Over Age 65, Disabled, Blind or Nursing Home Care These questions help us determine which program is best for each applicant and what services may be needed. In some cases, you will be referred to fill out an Appendix, which can be found in the Accompanying forms. Filling out the appendix is not required to submit your application, but may be needed later to see if you qualify.

If you are *under age 65 and disabled,* but **do not get** Social Security Disability or Supplemental Security Income (SSI), you will need to fill out Appendix A to start a Medical Review. Appendix A is not needed to submit your application, but will

be needed to see if you are disabled. It is ok to submit your application to the Family Support Division (FSD) before completing Appendix A.

If you are *blind or visually impaired,* you will also need to fill out Section 8 so we can determine if you qualify for Blind Programs. If you need help filling this out, you can call FSD at 1-855-373-4636.

If you *live in a nursing home* or similar facility**,** we need the name and address of the facility. If you are married and in a Nursing Care Facility, you may also need to fill out Appendix B if the month you entered the nursing home is different than the month you are applying for MO HealthNet.

Tell us if you want someone else to get information about your case and/or be able to discuss your case. If you have a conservator, guardian or an attorney-in-fact, you will need to provide a copy of the legal documents to the Family Support Division (FSD). If there is another person you want FSD to discuss your case with, or act on your behalf, fill out Appendix C to name an authorized representative and enter the representative's contact information on Page 6.

Section 2: Your Household

Name List your **spouse first**. Include information for everyone who lives with you, or would be if you weren't in a nursing home, even if they are not applying for MO HealthNet. It is important that you list everyone who lives with you so that we can make a correct eligibility decision. Include maiden name (legal name before marriage), if this applies to the person.

Ethnic Group/Race This information is optional, and it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes each person's race. You may pick more than one.

Relationship to You Explain how each person is related to the person applying on page 1 (For Example: spouse, child, step-child, brother, sister, niece, nephew, etc.).

Date and Place of Birth Include City and State of birth. If a person was born outside of the United States, write the country of birth.

Social Security Number A Social Security Number should be provided for all persons applying, if the person has one. If the person does not have a Social Security Number, leave this box blank. *(**NOTE:** Social Security numbers do not have to be given; however, if social security numbers are NOT given for the persons applying for coverage, the application cannot be approved.)*

Check if They're Applying Place a checkmark in the box to indicate which individuals are seeking coverage.

Are you married You must answer yes or no. Enter the date you got married.

Section 3: Your Money & Resources

Party to a trust You must answer yes or no. If you or your spouse is party to a trust as a grantor, trustee, or beneficiary, enter the name and date of the trust. Tell us your or your spouse's role in the trust.

The Family Support Division (FSD) will review all trust documents to determine availability of the resources in the trust to the applicant, or participant. Include a copy of the entire original trust and any amendments. Also, include documentation of funding sources or assets used to establish the trust. If the trust is established by an insurance payment or other settlement, include documentation to show settlement proceeds flow through the trust.

Cash and Securities Resources include cash, bank accounts, certificates of deposit as well as any item that can be converted to cash (i.e. cash value of life insurance policy). Tell us about all the assets owned by both spouses, whether the assets are owned solely or jointly by you and your spouse, or are owned jointly with another individual(s). Also, tell us about any asset owned at the time of institutionalization of an institutionalized spouse.

Pre-paid Burial Plans You must answer yes or no. Enter the name of the household member and the following plan information: Name of the Funeral Home, Policy or Contract Number and the Cash Surrender Value. Indicate if the plan is irrevocable. “Irrevocable” means that the plan cannot be canceled and you cannot get a refund.

Section 4: Your Income & Expenses

In this section, list all types of income (money received) and the amounts received by you and the people you listed in Section 2.

Unearned Income Includes Social Security benefits, disability payments, unemployment payments, interest and dividends, veterans’ benefits, Workers’ Compensation, child support payments/alimony, rental income, pension, annuities and trust income, any money received from relatives or friends, roomers or boarders (include money that anyone gives you each month to help meet living expenses).

Earned Income Includes wages, salaries, commissions, tips and any overtime. Please tell us how much you and/or your spouse make before taxes are taken out.

Self-Employment We need to know if you, or anyone in your household, is self-employed.

Shelter Expenses if you are Married and In a Nursing Home *(NOTE: Only married persons living in a nursing home need to complete the section.)* We need to know the monthly cost of housing paid by you or your community spouse. This includes your utilities, rent, monthly mortgage payment, other housing payment, real estate taxes and/or homeowners’ insurance, condo fees or telephone. Check the box for the expenses you pay and write in the amount you pay for these expenses. If you pay for your water, tell us how much you pay and how often.

If you share your housing expenses, or your rent is subsidized, please only tell us how much YOU pay toward your rent or mortgage.

Child Support or Alimony Payments that You Pay Fill this section out if you pay court ordered child support or alimony.

Section 5: Your Citizenship & Residency

Residency You must answer yes or no.

Citizenship You must answer yes or no. If you answer no, fill out the non-citizen information. This information is needed only for those people applying for health insurance.

To be eligible for MO HealthNet, individuals must be U.S. citizens or be in an eligible immigration category. We need to see either original documentation of U.S. citizenship and identity, or certified copies of these documents. Please note that if you are on Medicare, or receiving Social Security Disability or SSI; it is not necessary to document citizenship or identity.

Section 6: Your Personal Property

Transfer of Property or Resources You must answer Yes or No. If anyone in your home has sold or given away any money, vehicles, property or any other resources within in the last five years, answer the questions in this section.

Vehicles If no one in your household owns a vehicle, you need to check the appropriate response to this question.

Real Estate Property You must answer yes or no.

Section 7: Your Insurance

Life Insurance You must answer yes or no. If the answer is yes, write the name of the insured, the company, policy number and the cash surrender value of the policy, if any, in the boxes below.

Medicare You must answer yes or no.

Long-Term Care Insurance You must answer yes or no. If the answer is yes, write the name on the insured, the company, policy number and the monthly premium in the boxes below.

Health Insurance You must answer yes or no. It is important to tell us whether anyone applying has other health insurance. This information may affect their eligibility for coverage. For some applicants, we can deduct the amount that you pay for health insurance from the amount we count as your income; or we may be able to pay the cost of your health insurance premium if it is cost effective.

Section 8: Blind Pension & Supplemental Aid to the Blind

** SKIP THIS SECTION if you don't want Blind Pension or Aid to the Blind **

You must answer yes or no to each question.

Read and Sign: Rights and Responsibilities

Please read the paragraphs in this section carefully. If you do not wish to receive automated reminder calls, check the box provided.

You must sign and date the application.

Do you want to register to vote? Your answer will have no impact on your (or any family member's) eligibility for MO HealthNet benefits. You can download and print a voter registration card at http://dss.mo.gov/fsd/ and return the completed card with your application.

Hearing Rights You have the right to a hearing if you have applied for**,** or are receiving**,** Financial Assistance, MO HealthNet, or Food Stamp Benefits. If your application has been refused or rejected**,** or the planned action has already been taken, you may request a hearing within 90 days of the refusal or action. If the proposed action will change or stop your benefits**,** and you request a hearing within ten days from the date of the notice, you may continue to receive the same benefits until the hearing decision.

You or your representative may request a hearing by phone, in-person, or in writing. To request a hearing by phone, contact the Family Support Division (FSD) at 855-373-4636. You will be notified in writing of the date, time, and place for your hearing. You will be scheduled for a telephone hearing at your local FSD office.