MISSOURI FAMILY SUPPORT DIVISION

MO HEALTHNET ELIGIBILITY REVIEW INFORMATION

We are required to complete an annual review of MO HealthNet eligibility. In order to determine continued eligibility, we are asking you to complete all questions on this form. Race and ethnic group information is only for statistical use and is optional. The Social Security Number is required only for persons who are receiving or applying for MO HealthNet coverage.

After you have completed the form, please sign on the line indicated "Signature/Affidavit/Mark". Return this form to the return address above or to any local Family Support Division facility by *** _____***. Failure to return this form may result in MO HealthNet coverage being canceled. Contact the **Family Support Division Information Center at 855-373-4636** if you have any questions.

If employed, please include proof of your household income such as copies of your most recent paycheck stubs for 30 days, letter from your employer, or copies of your latest tax return if self-employed. Verification of resources such as bank statements, quarterly statements for retirement accounts or written statements from financial institutions is required. We need all income and resource information to check your eligibility for help paying for health coverage. We will check your answers using information in our electronic databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us additional information.

Do you want to register to vote? If so, just fill out the voter registration form included with the review form and return it to any local Family Support Division office or with this form.

Instructions: Please read each item carefully before you answer it. The answers you give will be used to determine continued eligibility for MO HealthNet. If you need assistance in completing the form, or have any questions, please contact the Family Support Division Information Contact Center. You must answer each question accurately and completely in ink. You may be required to provide verification of your statements. Attach an additional sheet or use the "Additional Information" section if more space is needed for any section.

Head of Eligibility Unit	Supercase	DCN	
Street Address	City	State	Zip
Current Phone	Work or Message Phone	Load Number	

Below, list your name first, then list all other persons who live with you.

Name (First, Middle, Last) (Maiden)	Hispanic Y/N	Race*/ Sex	Relationship to YOU	Birthdate	Social Security Number
			(self)		

*1 White 2 Black/African American 4 American Indian/Native Alaskan 5 Asian 6 Native Hawaiian/Pacific Islander 7 Two or more races

Do you or your spouse if married, reside in or plan to enter a Nursing or Residential Care Facility?
If Yes, who: _____
Where:_____ When: _____

I/We are residents of Missouri and intend to remain in Missouri. ☐ Yes ☐ No

Has there been any change in citizenship or immigration status for individuals currently in your household and receiving MO HealthNet? ☐ Yes ☐ No If Yes, list the individual whose status has changed with the current information in the blanks.

Name	Immigration Status	Registration Number	Date of Entry

MO HEALTHNET ELIGIBILITY REVIEW FORM

DCN:

Is anyone in the household blind or disabled? ☐ Yes ☐ No If Yes, who: _____

If you indicated that you are blind:

1. Do you have a sighted spouse? ☐ Yes ☐ No
2. Do you solicit alms? ☐ Yes ☐ No
3. Have you had eye surgery since the last review or application? ☐ Yes ☐ No
4. If you are under the age of 75, are you willing to have medical treatment or an operation to correct blindness? ☐ Yes ☐ No
5. If recommended, are you willing to accept vocational training or work at an occupation for which you are suited? ☐ Yes ☐ No
6. Do any household members, who are receiving Blind Pension benefits, have a valid driver license in any state or U.S. territory? ☐ Yes ☐ No If Yes, who: _____ Date of issue:_____
7. Has any household member operated a motor vehicle while receiving Blind Pension? ☐ Yes ☐ No If Yes, who: _____ Date:_____
8. Are you living in or supported by a public, medical or private institution? ☐ Yes ☐ No

CASH AND SECURITIES – PERSONAL PROPERTY

I/We have the following cash, securities, or personal property.	YES	NO	IN WHOSE NAME	LOCATION	VALUE
a. Checking account/joint checking accounts Account numbers:					
b. Savings accounts/joint savings accounts Account numbers:					
c. Patient accounts at a nursing home or other institution					
d. Savings or cash at home, on my person, or being held by someone else					
e. Stocks, bonds, or other investments. If yes, how many?					
f. Notes or mortgages owed to you/Promissory notes					
g. Trust funds Trustee Name and Phone Number:					
h. Annuity policies					
i. Certificates of Deposit					
j. Retirement funds					
k. Property in Probate Court					
l. Property held in Safe Deposit box (State location and contents of box)					

			LOCATION	VALUE	DEBT
m. House trailer (Mobile home)					
n. Jewelry (other than wedding and engagement rings, watches or costume jewelry)					
o. Business equipment					
p. Livestock, grain, produce, farm equipment, tools, etc					
q. Household Furniture Not In Use					
r. Other (Explain)					

r. Vehicles (include recreational and watercraft)	MAKE	YEAR	OWNER	LICENSED Y/N	VALUE	DEBT	HOW USED

MO HEALTHNET ELIGIBILITY REVIEW FORM

DCN:

REAL PROPERTY

I/We own or are buying real estate. ☐ Yes ☐ No

LIST KIND AND LOCATION	WHO HOLDS THE MORTGAGE?	LOAN NUMBER	WHOSE NAME IS ON THE DEED?	CURRENT VALUE	AMOUNT OWED	EQUITY	HOW IS IT USED?

TRANSFER OF PROPERTY OR RESOURCES

Has anyone in your home sold or given away any money, vehicles, property or other resources? ☐ Yes ☐ No

If yes, complete the following:

What? _____

When? _____

To Whom? _____

Why _____ Amount received $ _____

LIFE INSURANCE and/or PRE-PAID BURIAL PLAN

Does anyone in your home own a life insurance policy or pre-paid burial plan? ☐ Yes ☐ No

LIST PERSON INSURED	NAME OF COMPANY	POLICY NUMBER	FACE VALUE	PAID BY WHOM	DATE PURCHASED	IRREVOCABLE Y/N

HEALTH INSURANCE and/or LONG TERM CARE INSURANCE (other than MO HealthNet):

I/We have medical insurance. ☐ Yes ☐ No If Yes, complete the following:

Name of Insured	Name of Company	Policy Number	Policy Holder	Amount	Coverage Type (Doctor or Hospital) If limited, explain

INCOME

Please include proof of your income such as paycheck stubs for the last 30 days, letter from your employer, copies of your latest tax return if self employed, or award letter for Social Security or pensions. At your request these documents will be returned to you.

Is anyone in your household employed? ☐ Yes ☐ No If Yes, complete the following and attach verification:

NAME	EMPLOYER NAME	EMPLOYER PHONE	PAY RATE	PER*	CHECK DATE	DATE REC'D	GROSS INCOME	TIPS, ETC

*Hour Day Week Every two weeks Twice monthly Month

Does anyone in your household operate his/her own business or are otherwise self-employed? ☐ Yes ☐ No

If Yes, who: _____. If Yes, complete below and attach verification.

Describe the type of self-employment (babysitting, farm income, other) _____.

Enter amount earned _____ Per * ☐ Hour ☐ Day ☐ Week ☐ Every two weeks ☐ Twice monthly ☐ Month

Do you anticipate any changes in employment, hours worked or wages paid? ☐ Yes ☐ No

If Yes explain: _____

Is there anyone who plans to go to work? ☐ Yes ☐ No If Yes, who: _____

Where: _____ When: _____

MO HEALTHNET ELIGIBILITY REVIEW FORM

DCN:

Do you or any other household member receive money from any of the following sources?

	Yes	NO	Amount		Yes	No	Amount
Social Security				Union Funds or Pension Benefits			
Supplemental Security Income (SSI)				Insurance Settlements			
Alimony				VA Aid and Attendance			
Child Support payments				Armed Forces Allotment			
Money from others (friends, relatives, etc)				Room and/or Board Received			
Veteran's Benefits				Money from Sale of Property			
Worker's Compensation				Interest from Savings/Checking Account			
Unemployment Compensation				Income received from Trusts			
Disability or Sick Benefits				Income received from Annuities			
Income from Training Program				Rent received from Land/Buildings			
Any other income Explain:							

Has anyone recently applied for any of the above benefits? ☐ Yes ☐ No
If Yes, explain: _____

COLLATERAL INFORMATION

Please provide the names of two persons who live outside of your home and are not related to you, who can verify your statements.

Name	Name
Address	Address
Telephone Number	Telephone Number
This person is able to verify my statements because:	This person is able to verify my statements because:

ADDITIONAL INFORMATION: (If additional room is needed for any question please enter information here and attach verification as requested) _____

MO HEALTHNET ELIGIBILITY REVIEW FORM	DCN:

PLEASE READ CAREFULLY AND SIGN BELOW:

This is to certify under penalty of perjury that the forgoing information is true, accurate, and complete. I, (We), understand that any false claims, statements, or documents, or concealment of any material fact, may be prosecuted under applicable laws of the State of Missouri and/or the United States.

I, (We), further authorize the Department of Social Services, through the Director of Family Support or his appointee, to make an investigation of these circumstances and statements.

I, (We) understand if I/we disagree with the decision concerning our eligibility, I/we may request a fair hearing by contacting the local Family Support office. This request must be received within 90 days of the eligibility decision.

I, (We) understand that I/we must report any changes in circumstances within ten days of when they happen.

I, (We), will provide Social Security Numbers (SSN) of all persons applying for or receiving public assistance. It is a condition of eligibility except for Blind Pension. The SSN will be used to determine eligibility level of benefits, verify information, prevent duplicate participation and facilitate mass changes in Federal benefits (Section 1137 of the Social Security Act). Included in the agencies contacted for income and eligibility information are the Social Security Administration, the Internal Revenue Service, and the Missouri Division of Employment Security. Some of the information may be obtained by computer match.

I, (We), understand that I/we are entitled to fair and equal treatment regardless of race, color, religion, national origin, sex, ancestry, age, sexual orientation, veteran status, or disability.

I, (We), understand that the State of Missouri may file a claim against my/our estate to recover any assistance received. This does not apply to Qualified Medicare Beneficiary and Specified Low Income Beneficiary programs.

I, (We), understand that I/we must provide complete information regarding any health or accident insurance benefit available to any household member and I/we must report within 30 days any accident for which medical care is received.

I, (We), understand that application for and acceptance of MO HealthNet constitutes an assignment of rights to the Department of Social Services, MO HealthNet Division for payment for medical care from a third party.

Provided I/we are found to be eligible for assistance, I/we wish payments by the MO HealthNet Division and/or the Title XVII medical insurance program to be made directly to physicians and medical suppliers or any future covered unpaid bills for medical and other health services furnished me/us while eligible for MO HealthNet.

I/we understand that if I/we obtain or renew a driver license while receiving Blind Pension benefits I/we will be sanctioned from the Blind Pension program for 2 years, 4 years or permanently.

I/we understand that if I/we operate a motor vehicle while receiving Blind Pension benefits I/we will be santioned from the Blind Pension program for 2 years, 4 years or permanently.

ATTENTION: By signing this review, you are giving us permission to deliver, or cause to be delivered, phone calls to you regarding your case from an automated dialing system at the primary phone number you provided. You do not have to consent to this as a condition of eligibility. If you want to opt out of getting these calls, check here: ☐

My signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete to the best of my knowledge.

Signature/Affidavit/Mark	Date	Signature/Affidavit/Mark	Date

MO HEALTHNET ELIGIBILITY REVIEW FORM	DCN:

ATTENTION: Federal regulations require that the Missouri Department of Social Services (DSS) maintain a publicly available "Notice of Privacy Practices" that describes our policy for handling protected health information. The department has implemented a privacy policy and prepared a Notice of Privacy Practices. You may obtain a copy of this notice on the DSS Web site at http://www.dss.mo.gov/hipaa/hprivacy.pdf or from any county DSS office.

You may contact the Family Support Division by calling the FSD Information Center toll free Monday thru Friday 7am – 6pm at 1-855-373-4636 (1-855-FSD-INFO).

You may also call the Family Support Division Automated Line available 24 hours, 7 days a week at 1-800-392-1261.