Application for MO HealthNet (Medicaid) Appendices
Missouri Department of Social Services
Family Support Division

Appendices

Directions:

Filling out these forms may speed up the application process. They do not have to be submitted with the application.

- Fill out **Appendix A** on pages 2-10 if you are disabled but do not receive Social Security Disability or Supplemental Security Income (SSI).

- Fill out **Appendix B** on pages 11-14 if you are married and
  - living in a skilled nursing home (not assisted living), or
  - need skilled nursing care in your home.

- Fill out the form on **Page 16** if you would like to choose someone to represent you during the application process and/or after an eligibility determination is made.

- Fill out the form on **Page 18** if you want to allow the Family Support Division to discuss your case with a nursing home or medical provider.

Table of Contents:

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY users can call: 1-800-735-2966.

Application for MO HealthNet (Medicaid) Appendices
Missouri Department of Social Services
Family Support Division

Appendix A - Disability

Directions:

Filling out these forms may speed up the application process. They do not have to be submitted with the application.

- Fill out all 4 forms if you are disabled but do not receive Social Security Disability or SSI (Supplemental Security Income):

1. **Disability History**: Describe your disability in detail so we know what records or tests are needed (pages 3-4).

2. **Work History**: List where you have worked over the last 10 years so we know if you have been substantially and gainfully employed (pages 5-6).

3. **Provider History:** List the doctors, hospitals, and other providers who have treated your disability in the last 12 months so we can get your records faster (pages 7-8).

4. **Authorization to Release Health Information**: Allow us permission to get your medical records from your doctor and other providers (pages 9-10).

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY users can call: 1-800-735-2966.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

DISABILITY QUESTIONNAIRE

NAME	DCN	DATE

Pertinent Information and Observations of FSD Staff:

1. Personal Information: Age _____ Sex _____ Height _____ Weight _____
2. Highest Grade Completed: _____ GED ☐ Yes ☐ No

3a. What physical symptoms/problems do you have?

3b. What mental health symptoms/problems do you have?

Do you have crying spells or depression because of your disability? ☐ Yes ☐ No How often? _____

3c. Are your mental health symptoms due to your current circumstances (i.e. family, job, health)? ☐ Yes ☐ No

4. When did these symptoms/problems begin? _____
5. When did these symptoms first prevent you from working?
6. What are the limitations of your daily activities from this disability? Please list those you are **unable** to perform:

   Able to perform?

   Are you in need of caretaking? ☐ Yes ☐ No

   If yes, who provides? (Check one) ☐ Nurse ☐ Relative ☐ Neighbor ☐ Friend ☐ Other:
7. Did you see a doctor or seek medical treatment for your symptoms? ☐ Yes ☐ No

   Physician _____ How often? _____

   Treatment received _____

   When? _____

   Physician _____ How often? _____

   Treatment received _____

   When? _____
8. Have you been given a specific diagnosis for your problem? ☐ Yes ☐ No What is the diagnosis? _____

   _____
9. Have you gone to Vocational Rehabilitation? ☐ Yes ☐ No (If yes, obtain VR reports and any medical examinations required by VR) What is the status of your Vocational Rehabilitation referral?

10. Have you applied for (check if applicable)? ☐ Social Security ☐ SSI ☐ VA

Were you examined by a doctor for this application? ☐ Yes ☐ No (If yes, obtain medical reports from SSA)

What is the status of your application? _____

11. Did your problem require physical therapy? ☐ Yes ☐ No (Obtain medical information or reports)

If yes, where? When? _____

Describe therapy: _____

_____

12. Describe any pain you have from these problems. (If specialized care was received for this pain, obtain medical reports.)

13. List medications you take, prescribed or over-the-counter, side effects and how often medication is taken:

14. Who prescribed the medications? (Obtain medical information)

15. Have you been treated by or referred to a(n):	YES	NO	REFERRED	TREATED
Orthopedist	☐	☐	☐	☐
Internist	☐	☐	☐	☐
Neurologist	☐	☐	☐	☐
Cardiologist	☐	☐	☐	☐
Psychologist/Psychiatrist	☐	☐	☐	☐
Other specialist	☐	☐	☐	☐

16. Have you been hospitalized due to your disability or illness? ☐ Yes ☐ No

If yes, where? _____

How long? Dates? _____

Admitting physician name? _____

Medical information **must be current** (within the past 12 months). It must include information on each of the claimant's complaints. If not current or complete, schedule an examination.

ADDITIONAL INFORMATION AND COMMENTS

ITEM NO.	

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

WORK HISTORY - PAST 10 YEARS

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

Instructions: Please list all employers within the last ten (10) years, starting with the most recent. If you had more employers, please continue on a separate sheet and attach to this form.

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ❑ YES ❑ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ❑ YES ❑ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ❑ YES ❑ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ❑ YES ❑ NO	

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ❏ YES ❏ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ❏ YES ❏ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ❏ YES ❏ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ❏ YES ❏ NO	

EMPLOYER		TELEPHONE NUMBER
EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME $
JOB DESCRIPTION/DUTIES		
REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP? ❏ YES ❏ NO	

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

HOSPITALS, MEDICAL FACILITIES AND PHYSICIANS SEEN WITHIN THE PAST YEAR

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

Instructions: List all hospitals, medical facilities, and physicians that have provided care or services to you within the last year (12 months). If needed, use a separate sheet and attach to this form.

If you have not had any services in the last year, check here: ❑ NONE

DO YOU HAVE A PRIMARY CARE PHYSICIAN?

❑ YES ❑ NO If yes, list your primary care physician here:

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ❑ YES ❑ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ❑ YES ❑ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ❑ YES ❑ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ❑ YES ❑ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ❑ YES ❑ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ❑ YES ❑ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ❑ YES ❑ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ❑ YES ❑ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

STATE OF MISSOURI

AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, _____ authorize and request
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

- ☐ Department of Mental Health (DMH)
- ☐ Department of Health and Senior Services (DHSS)
- ☐ Department of Social Services (DSS)
- ☐ Department of Elementary and Secondary Education (DESE)
- ☐ Department of Corrections (DOC)
- ☐ Missouri Veterans Commission (MVC)
- ☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
WHO RECEIVED SERVICES FROM (DATES)		

to **(check all that apply)**

- ☐ Department of Mental Health (DMH)
- ☐ Department of Health and Senior Services (DHSS)
- ☐ Department of Social Services (DSS)
- ☐ Department of Elementary and Secondary Education (DESE)
- ☐ Department of Corrections (DOC)
- ☐ Missouri Veterans Commission (MVC)
- ☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

_____
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

- ☐ Eligibility Determination
- ☐ Assessment
- ☐ Aftercare
- ☐ Placement
- ☐ Transfer/Treatment
- ☐ Treatment Planning
- ☐ Continuity of Services/Care
- ☐ Conditional/Unconditional Release Hearing
- ☐ At Consumer's Request
- ☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, DOC, MVC, etc.) to obtain services consistent with the _____ program (please complete the name of the program in which you want to participate)
- ☐ Other (specify) _____

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Treatment Plan and/or Review
- ☐ Social Service Assessment
- ☐ Educational testing, IEP, transcript, and/or grading reports
- ☐ Medical/Psychiatric Assessment(s)
- ☐ Psychotherapy Notes
- ☐ Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.
- ☐ Other _____

MO 650-2616 (9-13)

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases or environmental conditions, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

   _____
3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
4. This authorization becomes effective on _____ . This authorization automatically expires on the following date, event or special condition _____ .
5. If I fail to specify an expiration date, this authorization will expire in one year.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

NOTICE OF REVOCATION

DATE

I, _____ , (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.

Application for MO HealthNet (Medicaid) Appendices
Missouri Department of Social Services
Family Support Division

Appendix B – Skilled Nursing Care

Directions:

Filling out these forms may speed up the application process. They do not have to be submitted with the application.

- **Declaration and Assessment of Assets** - Let us know about the assets (money and property) you owned at the time you entered the nursing home, or when your need for in-home care started.

  This list allows us to determine how much of the assets your spouse can keep while you are receiving MO HealthNet nursing care coverage.

  - Both you and your spouse must sign at the bottom of the last page.
  - If you own your home, provide a copy of the deed.
  - We will need proof of your assets. You may provide these with this form, or we can get this from you later.

You do not need to fill out this form unless you are married and either you or your spouse lives in a nursing home or needs skilled nursing care at home.

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY users can call: 1-800-735-2966.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

DECLARATION AND ASSESSMENT OF ASSETS

IDENTIFYING INFORMATION

INSTITUTIONALIZED SPOUSE	DCN	NAME		SOCIAL SECURITY NUMBER	
TELEPHONE NUMBER	ADDRESS (STREET, CITY, STATE, ZIP CODE)		RACE	SEX	BIRTHDATE
COMMUNITY SPOUSE	DCN	NAME		SOCIAL SECURITY NUMBER	
TELEPHONE NUMBER	ADDRESS (STREET, CITY, STATE, ZIP CODE)		RACE	SEX	BIRTHDATE

DATE ASSESSMENT REQUESTED	DATE INSTITUTIONALIZED	VENDOR NAME	**COUNTY USE ONLY**			
OTHER INSTITUTION NAME AND ADDRESS			VENDOR NUMBER		LIKELY TO REMAIN INSTITUTIONALIZED ☐ YES ☐ NO	
ASSESSMENT DECISION ▸	TOTAL NON-EXEMPT ASSETS $	SPOUSAL SHARE $	DATE ASSESSMENT COMPLETED	REASON INACTIVE		DATE LEFT INSTITUTION
COUNTY NAME AND ADDRESS		TELEPHONE NUMBER	COUNTY NO.	ELIG. SPEC. NO.	LOAD NO.	SUPERVISOR NUMBER

INCLUDE ALL THE REAL AND PERSONAL PROPERTY OWNED BY THE SPOUSE WHO IS INSTITUTIONALIZED AND THE SPOUSE WHO LIVES AT HOME FOR THE MONTH OF ▸

1. I/We have the following cash and securities.	YES	NO	IN WHOSE NAME	LOCATION	VALUE	EX-EMPT	EQUITY	HOW VERIFIED
A. Checking account/joint checking accounts								
Account Numbers:								
1)	☐	☐						
2)	☐	☐						
3)	☐	☐						
	☐	☐						
B. Savings Accounts, Joint Savings Accounts, Christmas Club Savings, Time Certificates or Deposit in Credit Union.								
Account or Certificate Numbers:								
1)	☐	☐						
2)	☐	☐						
3)	☐	☐						
4)	☐	☐						
5)	☐	☐						
	☐	☐						
C. Patient accounts at nursing home or other institution.	☐	☐						
D. Savings or cash at home, on my person, or being held by someone else.	☐	☐						

INSTITUTIONALIZED SPOUSE NAME			DCN			COUNTY USE ONLY		
E. Stocks	YES	NO	IN WHOSE NAME	LOCATION	VALUE	EX-EMPT	EQUITY	HOW VERIFIED
Company and number of shares								
1)								
2)								
3)								
F. Bonds or other investments								
1)								
2)								
3)								
G. Notes or Mortgages owed to you (Does any one owe you money?)								
H. Trust Funds								
I. Property held in Safe Deposit Box Contents								
2. I/We have the following personal property:			LOCATION	VALUE	DEBT			
A. Household Furniture (in use)								
B. Household Furniture (not in use)								
C. Housetrailer (mobile home)								
D. Jewelry (other than wedding and engagement rings, watches or costume jewelry)								
E. Business equipment								
F. Farm machinery								
G. Farm grain and produce								
H. Farm livestock								
I. Property Claims in Probate Court								
J. Burial Plot(s)								
K. Other (list):								

INSTITUTIONALIZED SPOUSE NAME	DCN

COUNTY USE ONLY

L. List any vehicles you or your spouse own or are buying (Include cars, trucks, vans, motorcycles, boats, recreational vehicles, tractors, others).

MAKE	MODEL	YEAR	OWNER	VALUE	DEBT	HOW IS VEHICLE USED	EX-EMPT	EQUITY	HOW VERIFIED

3. I/WE ARE BUYING OR OWN REAL ESTATE ☐ YES ☐ NO IF YES, LIST BELOW

LIST KIND AND LOCATION	WHO HOLDS MORTGAGE?	LOAN NUMBER	WHOSE NAME ON DEED	CURRENT VALUE	AMOUNT OWED	HOW IS IT USED? HOME/RENTAL	EX-EMPT	EQUITY

4. I/WE HAVE LIFE INSURANCE, PREPAID BURIAL PLANS OR BURIAL FUNDS. ☐ YES ☐ NO IF YES, LIST BELOW

PERSON INSURED	COMPANY NAME	POLICY NUMBER	EX-EMPT	EQUITY

Spousal share is the amount of non-exempt assets that may be disregarded in initial eligibility determinations for nursing care vendor benefits for the institutionalized spouse during this continuous period of institutionalization.

TOTAL NON-EXEMPT ASSETS	SPOUSAL SHARE
$	$

I/we understand that this assessment is valid for this continuous period of institutionalization in a MO HealthNet certified bed or hospital.

I/we understand that we do not have the right to appeal the determination of the value of non-exempt assets or the spousal share until such time as the institutionalized spouse applies for nursing care vendor benefits.

I/we understand that we MUST immediately notify the Family Support Division when

- the institutionalized spouse is discharged from the nursing home or hospital
- either spouse dies
- we become divorced
- the spouse who lives at home goes into a nursing home or hospital for 30 days or longer

I/we the above named requestor(s) or representative(s) do solemnly swear that I/we fully and clearly understand the questions set forth and that I/we have truthfully and to the best of my/our ability given the answer to each question.

SIGNATURE OF INSTITUTIONALIZED SPOUSE ▸	DATE	SIGNATURE OF COMMUNITY SPOUSE ▸	DATE
WITNESS	DATE	WITNESS	DATE
WITNESS	DATE	WITNESS	DATE

ELIGIBILITY SPECIALIST SIGNATURE ▸	DATE
SUPERVISOR SIGNATURE ▸	DATE

☐ THE ASSESSMENT WAS NOT COMPLETED BECAUSE

Application for MO HealthNet (Medicaid) Appendices
Missouri Department of Social Services
Family Support Division

Appendix C - Consent

Directions:

Filling out these forms may speed up the application process. They do not have to be submitted with the application.

1. **Appointment of Authorized Representative** - Name of who you want to represent you.

   Do not fill out this form for your lawyer, power of attorney, conservator, or guardian. Instead:

   - For your lawyer, provide the lawyer's Entry of Appearance.
   - For your power of attorney, provide power of attorney papers.
   - For your conservator or guardian, provide the court order granting conservatorship or guardianship.

2. **Consent to Release Health Information** – Fill out this form if you want to allow the Family Support Division to discuss your case with a nursing home or medical provider.

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY users can call: 1-800-735-2966.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPOINTING AN AUTHORIZED REPRESENTATIVE

Use this form if you would like an authorized representative to help you apply for MO HealthNet coverage, Temporary Assistance, Food Stamps, Child Care Subsidy, and/or act on your behalf if you get MO HealthNet coverage, Temporary Assistance, and/or Food Stamps.
If you are a resident of a Drug and Alcohol treatment and rehabilitation program and you want to apply for Food Stamp benefits, you must appoint an authorized representative who is employed by the treatment facility to apply and access benefits for you.
If you reside in a group home and are eligible for Food Stamp benefits on your own, you do not need to sign this form to apply for or receive Food Stamp benefits.
You can choose to have an authorized representative or you can act on your own behalf. If you already have a guardian, conservator, or attorney-in-fact appointed by a valid Power of Attorney under Missouri law, they must appoint an authorized representative for you. Even if you choose to have an authorized representative, the FSD may sometimes need to contact you directly.

Instructions:
1. Fill out and sign your name(s) in Sections 1 and 2. Only one (1) form is necessary if the same authorized representative is being appointed for both members of a married couple or yourself and a second parent.
2. Have the person, facility, or organization you're appointing fill out and sign their name in Section 3 to verify they accept the responsibilities listed below.
3. Return your completed form to the FSD **within 30 days** of the date(s) you and your authorized representative sign and date the form.

SECTION 1: YOUR INFORMATION AND AUTHORIZATION TO BE REPRESENTED

YOUR NAME(S)	TELEPHONE NUMBER

HOME ADDRESS	MAILING ADDRESS

DATE OF BIRTH OR DCN (CASE NUMBER)

I APPOINT AS MY/OUR AUTHORIZED REPRESENTATIVE:

NAME

MY AUTHORIZED REPRESENTATIVE IS ONE OR MORE OF THE FOLLOWING (CHECK ALL THAT APPLY):

- ☐ Spouse
- ☐ Legal Guardian
- ☐ Attorney
- ☐ Public Administrator
- ☐ Department of Mental Health
- ☐ Conservator
- ☐ Power of Attorney
- ☐ None of these

By appointing an authorized representative, you are consenting to allow FSD to send letters and notices to your authorized representative.

For Food Stamps, I/we authorize this person or organization to be responsible for (check one or more boxes):
- ☐ Helping me/us apply for Food Stamp benefits, including annual reviews, reporting changes, and receive notices.
- ☐ Access my benefits (EBT card)
- ☐ Access FSD account online communications
- ☐ Access FSD account online communications only after I am deceased

For Temporary Assistance (TA), I/we authorize this person to be responsible for (check one or more boxes):
- ☐ Helping me/us apply for TA benefits which includes acting on my/our behalf if I/we are approved for TA benefits, including annual reviews, reporting changes, and receiving notices.
- ☐ Access FSD account online communications
- ☐ Access FSD account online communications only after I am deceased

MO HealthNet, if your authorized representative helps you apply, your authorization will last until FSD makes a final decision on your application, or you can end it sooner if you notify FSD in writing. If your authorized representative acts on your behalf, your authorization will last until you end it by notifying FSD in writing.

I/we authorize this person or organization to be responsible for (check one or more boxes):
- ☐ Helping me/us apply for MO HealthNet coverage
- ☐ Acting on my/our behalf if I/we get MO HealthNet coverage, including annual reviews, and reporting changes.
- ☐ Access FSD account online communications
- ☐ Access FSD account online communications only after I am deceased.

For Child Care Subsidy, I/we authorize this person or organization to be responsible for:
- ☐ Helping me/us apply for Child Care Subsidy benefits

The person or organization I/we have appointed is age 18 or older and knows my/our situation well enough that they can complete my/our application and act on my/our behalf. They will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation, or rule of this State or the United States.

NOTE: Organizations may not be appointed for Temporary Assistance applicants or recipients.

I/we understand that I/we am responsible for the information given by my/our authorized representative, including any information that may be incorrect.

YOUR (APPLICANT/PARTICIPANT) SIGNATURE	DATE
YOUR SPOUSE'S OR SECOND PARENT SIGNATURE	

SECTION 2: YOUR AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND OTHER INFORMATION (For MO HealthNet Programs; OPTIONAL FOR Food Stamp, Child Care and Temporary Assistance programs)

Please write your name and the name of a person who can receive **protected health information** (PHI) and other information about you. Write the name of a person, **not** an organization. You may skip this section if you are appointing your spouse, attorney, attorney-in-fact, guardian, conservator, or court appointed public administrator to act as your authorized representative.

I/We, (your name(s))_____ _____,
request and authorize Family Support Division to disclose information to this person:

REPRESENTATIVE NAME

Because I'm/we're giving this request and authorization, FSD may release to the person named above:

- Requests for information
- Eligibility notices and medical information about this application
- My/our annual review
- Letters about agency action

This authorization will continue during the final decision on my/our application, my/our annual review, or agency action for which I/we gave this authorization. If I/we want to end my authorization sooner, I/we must tell the FSD in writing before the final application, annual review, or agency action decision.

I/we understand that FSD is not responsible for what happens to information they release because I/we have requested and authorized them to disclose my/our Protected Health Information. I/we understand and agree that FSD has given me/us a signed copy of this form.

YOUR (APPLICANT/PARTICIPANT) SIGNATURE	DATE

YOUR SPOUSE'S OR SECOND PARENT'S SIGNATURE

SECTION 3: AUTHORIZED REPRESENTATIVE AGREEMENT AND ACCEPTANCE

Individual acting as Authorized Representative: Please fill out and sign this section.

REPRESENTATIVE'S NAME	TELEPHONE NUMBER

REPRESENTATIVE'S MAILING ADDRESS

REPRESENTATIVE'S DATE OF BIRTH (TEMPORARY ASSISTANCE)

I am age 18 or older and know the applicant's situation well enough to complete their application or act on their behalf. I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation or rule of this State or the United States.

I agree to be the applicant's authorized representative for the reason(s) stated on this form. I will protect the privacy of any information I get while acting as authorized representative as required by Federal, State and local laws, regulations, ordinances, and directives about privacy.

AUTHORIZED REPRESENTATIVE'S SIGNATURE	DATE

Individual acting as authorized representative due to affiliation with an organization or facility: Please fill out and sign this section.

ORGANIZATION OR FACILITY NAME

ORGANIZATION OR FACILITY ADDRESS

ORGANIZATION OR FACILITY E-MAIL	ORGANIZATION OR FACILITY TELEPHONE

I represent the organization or facility named above. I have provided proof of my identity to the Family Support Division. I have knowledge of the applicant's or participant's situation well enough to complete their application or act on their behalf. I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation, or rule of this State or the United States.

I will report changes to FSD on behalf of the participant as needed. I will inform FSD if I am no longer an authorized representative.

I understand I must do the following once I stop being an authorized representative:

- Immediately stop using the EBT card.
- Notify FSD of the change in authorized representative status within 48 hours.

I agree to be the applicants authorized representative. I will protect the privacy of any information I get while acting as an authorized representative as required by Federal, State, and local laws, regulations, and directives about privacy.

AUTHORIZED REPRESENTATIVE'S SIGNATURE	DATE

Need Help?

- By Phone: **1-855-FSD-INFO (1-855-373-4636)**
- Online: **mydss.mo.gov**
- In person: **Visit any FSD Office.** To find an office in your area, call the number above or visit us online.

AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION NURSING FACILITIES, IN-HOME NURSING CARE PROVIDERS, AND OTHER PROVIDERS OF MEDICAL SERVICES

I _____do hereby authorize and request that the State of Missouri, Department of Social Services, Family Support Division, release or disclose to the following organization or person: _____ *(person/organization name)* at_____*(address)*, _____ *(telephone number)*, the financial and health information of the person listed below:

NAME ON INFORMATION TO BE DISCLOSED	BIRTH DATE	SOCIAL SECURITY NUMBER OR DCN

THE SPECIFIC INFORMATION TO BE DISCLOSED IS ALL FINANCIAL AND MEDICAL INFORMATION OF THE ABOVE NAMED INDIVIDUAL, INCLUDING, BUT NOT LIMITED TO, DOCUMENTS AND INFORMATION NECESSARY TO COMPLETE THE FOLLOWING PURPOSES.

THE PURPOSE OF THIS REQUEST IS TO:

- ☐ ASSIST WITH APPLICATION FOR MO HEALTHNET BENEFITS
- ☐ ASSIST WITH RENEWAL OF ELIGIBILITY FOR MO HEALTHNET BENEFITS
- ☐ ASSIST WITH POSSIBLE CHANGES IN ELIGIBILITY FOR MO HEALTHNET BENEFITS

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

You cannot be required to sign this disclosure authorization form. Your MO HealthNet application will not be denied if you do not sign this form. If you do not sign this form, your benefits could be delayed because necessary information may not be promptly provided to Family Support Division. If you do sign this form, you must be given a copy. You have the right to inspect the information to be disclosed and you may revoke this authorization at any time by writing the facility named above and the DSS Privacy Officer at PO Box 1527, Jefferson City, MO 65102. A revocation of this authorization will not reverse disclosures of information already made under the authorization. You understand that once information is released to the above named facility or individual specified above, your information may be subject to re-disclosure. Alcohol and drug abuse treatment records are specifically protected by federal regulations (42 CFR Part 2) and by signing this authorization, without restriction, you are allowing the release of all medical records including any alcohol and/or drug records that may be in your files to the above named facility or individual specified above. If you do not want your alcohol and/or drug records released, initial in the following box: ☐

SIGNATURE

I have had an opportunity to review and understand the content of this authorization form, and by signing this authorization, I confirm it accurately reflects my wishes. **Note: If a guardian, legal representative or a personal representative signs this document; they must provide separate documentation of their status and authority to sign this authorization to the Family Support Division along with the signed authorization.**

SIGNED (INDIVIDUAL, GUARDIAN, LEGAL OR PERSONAL REPRESENTATIVE)	DATE

ADDRESS

EXPIRATION DATE – This authorization is good until _____ or one year from signature if no date entered.

PLEASE RETURN REQUESTED INFORMATION TO FOLLOWING HCBS PROVIDER OR NURSING HOME UNIT:

OFFICE	TELEPHONE NUMBER

ADDRESS

PLEASE PROVIDE AN E-MAIL ADDRESS

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