FAMILY SUPPORT DIVISION
REINVESTIGATION—ELIGIBILITY STATEMENT

IM-2D (FSD/DMH)
(Rev.8/05)

Case Name _____Case No._____ Worker:_____ Load No: _____

Date:_____ OV ____ HV ____ Other: _____State Hospital ☐ IMR ☐ SP (OAA ☐ PTD ☐ AB ☐) MA ☐ SNC ☐ SAB ☐ BP☐ ☐ MAF *MC*+ ☐

THE FAMILY SUPPORT DIVISION IS REQUIRED TO REVIEW THE ELIGIBILITY OF PERSONS RECEIVING ASSISTANCE AT LEAST ONCE A YEAR. IN ORDER TO DETERMINE ELIGIBILITY WE ARE ASKING THAT YOU COMPLETE ALL SECTIONS OF THIS FORM. IF IT WAS MAILED TO YOU, RETURN IT IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.

A. ADDRESS:_____

YOUR TELEPHONE NUMBER_____ TELEPHONE NUMBER WHERE YOU MAY BE REACHED_____

B. CITIZENSHIP AND RESIDENCY

I/We are United States Citizens. Yes ☐ No ☐ If no, are you a legal alien? Yes ☐ No ☐
If an alien, list current immigration status and alien registration number: _____
I/We are residents of Missouri and intend to remain. Yes ☐ No ☐

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CITIZENSHIP/RESIDENCY
Citizen or legal alien; Yes ☐ No ☐
If legal alien verify status using ASVI/SAVE
Intends to remain in Missouri:
Yes ☐ No ☐

C. LIST ALL OF THE PERSONS WHO LIVE IN YOUR HOME (List your name first)

Name First, Middle, Last (Maiden)	Race/ Sex	Relationship (son, sister, friend)	Birth Date	Social Security Account Number	Social Security Claim Number
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Do you wish to start coverage for any of the above persons who are not currently covered by Medicaid or *MC*+? Yes ☐ No ☐ If Yes, who?

Is anyone in the household pregnant? Yes ☐ No ☐ If Yes, who? Expected Due Date:

AGE VERIFICATION
IM-36 complete: ☐

D. INSURANCE

I/We have Life, Medical, Hospital Insurance, Medicare or Prepaid Burial Plans: Yes ☐ No ☐

List Person Insured	Name of Company	Kind of Insurance	Policy Number	Face Value	Amount of Premium and How Often Paid

INSURANCE NA ☐
IM-9 or Policy
IM-37 Completed/Review/Updated:
Date:_____
TPL-1 sent: Date: _____
QMB – MEDICARE PART A & B N/A☐
IIVE/TPQY Date: _____
Part A Entitlement: _____
(date)
Part B Entitlement:_____
(date)
Note: QMB eligibility date may not precede Part A Enrollment date. Also eligibility cannot begin until the month following the month of approval.

E. CASH AND SECURITIES—PERSONAL PROPERTY

1. I/We have the following cash, securities, or personal property:	YES	NO	IN WHOSE NAME	LOCATION	VALUE
a. Checking Account/Joint Checking Accounts, Savings Accounts, Joint Savings Accounts, Christmas Club Savings, Time Certificates, or Deposit in Credit Union (List Account Numbers:)					
b. Patient accounts at a nursing home or other institution					
c. Savings or cash at home, on my person, or being held by someone else					
d. Stocks, bonds, or other investments. If yes, how many?					
e. Notes or mortgages owed to you					
f. Property held in a Safe Deposit Box (State location and contents of box)					
			LOCATION	VALUE	DEBT
g. Household Furniture (in use)					
h. Household Furniture (not in use)					
i. Trust Funds					
j. House trailer (Mobile Home)					
k. Jewelry (other than wedding and engagement rings, watches, or costume jewelry)					
l. Business equipment					
m. Farm Machinery					
n. Farm grain and produce					
o. Farm Livestock					
p. Property Claims in Probate Court					
q. Other					

r. Vehicles:	Owner	Make/Model	Year	Licensed?	Value	Debt	How used
				Yes ☐ No ☐			

F. REAL PROPERTY

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

Kind & Location	Mortgage Holder	Loan Number	Names on Deed	Current Value	Amount Owed	Equity	How is it used

G. TRANSFER OF PROPERTY OR RESOURCES

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

If yes, complete the following:

What? _____

When? _____

To Whom? _____

Why? _____ Amount Received $: _____

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CASH AND SECURITES: NA ☐
IM-7 Received: _____
(date)
(Filed in case record)
Record any other verification used:

PERSONAL PROPERTY:

REAL PROPERTY: NA ☐
IM-8 Received: _____
(Filed in case record)
Record any other verification used:
IM-43, 43-A, Other

TOTAL AVAILABLE RESOURCES:

Cash Surrender Value: $_____

Cash and Securities: $_____
Available Personal Property $_____
Available Real Property $_____

TOTAL $_____

TRANSFER OF PROPERTY
Consider time limitations; verify and record eligibility

H. INCOME

I am/We are employed. Yes ☐ No ☐ Where? _____
Amount you are paid before deductions? $ _____

I/we receive income from:	Yes	No	Amount
Self employment:	☐	☐	$_____
Property Rental:	☐	☐	$_____
Child Support Payments:	☐	☐	$_____
Interest or Dividends:	☐	☐	$_____
Social Security Benefits (Retirement, Disability, or Survivors):	☐	☐	$_____
Supplemental Security Income (SSI Benefits from Social Security):	☐	☐	$_____
Veterans Benefits:	☐	☐	$_____
Railroad Retirement:	☐	☐	$_____
Armed Forces Allotments:	☐	☐	$_____

	Yes	No	Amount
Unemployment Compensation:	☐	☐	$_____
Assistance from friends or relatives:	☐	☐	$_____
Assistance or Food Stamps from another state:	☐	☐	$_____

Other:

(Explain below where the money comes from and the amount)

_____

_____

_____

Child care costs may be an allowable income deduction for working families. Do you pay someone to care for your child? Yes ☐ No ☐
If Yes, list the names of the children cared for: _____
How much do you pay for child care: _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly

I. COLLATERAL (REFERENCE) 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: _____
Address: _____
Telephone Number: _____
This person is able to verify my statements because:
_____

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

J. SUPPLEMENTAL AID TO THE BLIND OR BLIND PENSION

1. Do you have a sighted spouse or parent? Yes ☐ No ☐
2. Do you solicit alms? Yes ☐ No ☐

K. IF RECEIVING BLIND PENSION, COMPLETE THE FOLLOWING QUESTIONS ALSO

1. Have you had eye surgery since the last review of your case? Yes ☐ No ☐
2. If you are under age 75, are you willing to have Medical Treatment or an operation to correct blindness? Yes ☐ No ☐
3. If recommended, are you willing to accept Vocational Training or work at an occupation for which you are suited? Yes ☐ No ☐
4. Are you living in or supported by a public, medical, or private institution? Yes ☐ No ☐

L.. MEDICAL ASSISTANCE OR SUPPLEMENTAL NURSING CARE

1. Do you live in or plan to enter a Nursing Home? Yes ☐ No ☐

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EMPLOYMENT/INCOME
Wage information:
IM-12, Wage Stubs, IMES printout, Work Number, other
All verification and recording of income and expenses must be done on the appropriate budget (IM-30, IM-30 IBCA, IM-30A, IM-30B).

UNEARNED INCOME
Possible sources of verification:
IM-7, IM-12, IM-13, IM-41, IM-76, IIVE, Printout, Check Stubs, Case Record, Other.

Explore potential eligibility for OASI, RSDI, VA, SSI, etc., explain if necessary

COLLATERAL
Identify collateral; date contacted, qualifications and information received.

SAB-BP
IM-2B: Date: _____
Parent or sighted spouse able to support:
NA ☐ Yes ☐ No ☐

BP Only: IM-2A: Date: _____

SSI/RRB: (IM-76, SDX)
NA ☐ Yes ☐ No ☐
If no, explain:

MEDICAL ASSISTANCE FOR FAMILIES (MAF) OR *MC* + ONLY

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M. ABSENT PARENT INFORMATION

Are both of the parents of all the children in the home? Yes ☐ No ☐ If no, please answer the following two questions:

1. Do you have any new information about an absent parent(s)? Yes ☐ No ☐ If Yes, please give details._____

2. Do you have a good reason for not cooperating in obtaining support for medical care? Yes ☐ No ☐ If Yes, please give details.

Complete verification and case recording for MAF and/or MC+ on the Eligibility Recording form (IM2U)

N. HEALTH INSURANCE (*MC* + ONLY)

1. Does anyone in your home have medical, hospital insurance or Medicare? Yes ☐ No ☐ If Yes, please list details below

PERSON INSURED	NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
		☐ Doctor ☐ Hospital if limited coverage explain:
		☐ Doctor ☐ Hospital if limited coverage explain:

2. Has anyone in your home lost or dropped health insurance in the past six months? Yes ☐ No ☐ If yes, please provide the name(s), date and the reason coverage ended. _____

3. Is health insurance available for any member of your family through an employer or other group membership?
   Yes ☐ No ☐ If yes, please name the employer or group _____
   Is the insurance available for ☐ Self ☐ Spouse ☐ Children How much is the premium for the children? _____ per _____

4. **Do any of your children have a medical condition that left untreated would result in death or serious physical injury of the child?** Yes ☐ No ☐ **If yes, provide the name(s) of the child(ren)** _____

5. Please refer to the income guidelines of the MC+ program. If income and family size fall in the premium group, submit 2 quotes from private insurance companies of what they would charge for medical coverage for all of your children.
   Quote #1: $ _____per month. Company _____. Quote #2: $ _____per month. Company_____.

DECISION:
Eligible ☐

Rejection: ☐ Reason:

Closing: ☐ Reason:

Decision Date: _____
Prior Quarter Coverage:
Yes ☐ No ☐ If No, explain

Priority: Yes ☐ No ☐
Date: _____
SERVICES:
B-2 Yes ☐ No ☐
HCY: Yes ☐ No ☐
IM-54: Yes ☐ No ☐

Q. NET WORTH (*MC*+ Only)

Is your net worth (Net worth is the value of everything you own minus any debt.) ☐ less than $50,000 ☐ $50,000—$100,000 ☐ $100,000--$150,000 ☐ $150,000--$200,000 ☐ $200,000--$250,000 ☐ above $250,000
Please list your assets (bank accounts, stocks/bonds, vehicles, home, real and personal property, etc.) _____

I, (We), further authorize the Department of Social Services, through the Director of Family Support Division or his appointee, to make an investigation of these circumstances and statements. I, (We), will provide Social Security Numbers (SSN) of all persons applying for or receiving public assistance if it is a condition of eligibility. The SSN will be used to determine eligibility and 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), will notify the Department of Social Services promptly of any changes in income, expenses, property holdings, financial conditions, household composition, and of any change in address. This is to certify under penalty of perjury that the foregoing 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. It is a crime, and upon conviction punishable by imprisonment by the Missouri Department of Corrections for a period not to exceed five years; or by confinement in the county jail for a period not to exceed one year; or by fine not to exceed one thousand dollars; or by both, where an act or series of acts a person defrauds the state of one hundred fifty dollars or more or a misdemeanor if the amount is less than one hundred fifty ($150) dollars. Where the person applies to receive monetary payments, hospital, medical, dental, or pharmaceutical service or commodity provided pursuant to provisions of Chapter 208 or 209 RSMo and the person shall knowingly: (a) Make, or (b) cause to be made, or (c) aids or abets another in the making of any false statements or misrepresentation of any fact required to be reported either by law or by rule or regulation of this state or of the United States in applying for Public Assistance or any fact used In the determination of any person's initial or continued eligibility for any public assistance with the intent to secure public assistance when not entitled to public assistance or with intent to secure more public assistance benefit that the person is entitled to. The same penalties apply to any person who knowingly (a) conceal or (b) knowingly fails to report or (c) knowingly causes the concealment or failure to report or (d) knowingly aids or abets another in the concealment or failure to report any fact or event required to be reported in applying for or used in the determination of any persons initial or continued eligibility for public assistance or food stamps or to secure public assistance or food stamps in an amount greater than entitled to receive.

_____
(Signature of applicant/recipient and spouse or mark) (Date)

_____
(Signature of Caseworker or witness if signed by mark) (Date)