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

¿Necesita ayuda con su aplicación?
Llámenos al 1-855-373-4636. Si necesita ayuda en una lengua que no sea el inglés, dígale al representante de servicio al cliente la lengua que usted necesite. Los usuarios de teléfonos de texto pueden llamar al: 1-800-735-2966. Si usted es ciego o tiene una discapacidad visual y desearía informacion sobre los Servicios de Rehabilitación para Invidentes, por favor llame al 1-800-592-6004.

Send completed application
to: Greene County FSD
101 Park Central Square
Springfield MO 65806
Fax: (417) 895-6080
or Apply online at
https://mydss.mo.gov/

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPLICATION FOR MO HEALTHNET (MEDICAID)

FOR OFFICE USE ONLY

DATE APPLIED

SECTION 1: Your Basic Information

DCN #1 | DCN #2

APPLICANT FULL LEGAL NAME (FIRST, MIDDLE, LAST) | MAIDEN NAME (IF ANY)

HOME ADDRESS (HOUSE NUMBER, STREET OR RURAL ROUTE, PO BOX, HOMELESS) | CITY, STATE, ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS) | CITY, STATE, ZIP CODE

PRIMARY PHONE NUMBER ☐ Cell ☐ Home ☐ Work ☐ Other: _____ | ALTERNATE PHONE NUMBER ☐ Cell ☐ Home ☐ Work ☐ Other: _____

E-MAIL ADDRESS

PREFERRED METHOD OF CONTACT
☐ Call ☐ *Text ☐ E-mail ☐ Mail *Texting is not available in all locations.

SOCIAL SECURITY NUMBER	DATE OF BIRTH	PLACE OF BIRTH	RACE* (OPTIONAL)	SEX ☐ M ☐ F	HISPANIC (OPTIONAL) ☐ YES ☐ NO

* 1. CAUCASIAN 2. BLACK/AFRICAN AMERICAN 3. AMERICAN INDIAN/ALASKA NATIVE 4. ASIAN 5. NATIVE HAWAIIAN/PACIFIC ISLANDER

I, the above named applicant, apply for MO HealthNet under the laws of the state of Missouri.

Check any of these that apply to you **or your spouse if your spouse wants coverage.**

☐ I/We are over age 65.

☐ I/We are disabled and get Social Security disability or SSI.

☐ I/We are disabled and do not get Social Security disability or SSI.
If you check this box, also fill out Appendix A to help determine if you meet the disability requirements.

☐ I/We are blind or visually impaired.
If you check this box, also fill out section 8 of this application to see if you qualify for Blind programs.

☐ I/We live in a nursing home or similar facility.
If you check this box, please list:

FACILITY NAME

FACILITY ADDRESS

☐ I/We are age 63 and over and need in-home nursing care.
If you check this box, also fill out Appendix B if you're married, and one of you either lives in a nursing home or needs skilled nursing care at your home.

☐ I/We need help paying for Medicare premiums and co-insurance costs.

☐ I/We work and pay income taxes, and want coverage under the Ticket to Work program.
If you check this box, this may let you qualify for MO HealthNet by paying a premium.

☐ I/We need help with medical bills from the last 3 months.

☐ I/We have a conservator, guardian, attorney-in-fact, or another person to represent us.
If you check this box, fill out Appendix C to name an authorized representative, or provide conservator, guardian, or power of attorney documents. Then fill out the representative's contact information on page 7.

All applicants must fill out sections 2 through 7

SECTION 2: Your Household

Below, **list your spouse first**, then anyone who lives with you, or would be if you weren't in a nursing home.

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	HISPANIC Y/N (optional)	RACE* (optional)	SEX	RELATIONSHIP TO YOU (spouse, son, sister, friend)	DATE OF BIRTH	CHECK (✓) IF THEY'RE APPLYING	SOCIAL SECURITY NUMBER (if applying)	PLACE OF BIRTH (if applying)
						☐		
						☐		
						☐		
						☐		

* 1. CAUCASIAN 2. BLACK/AFRICAN AMERICAN 3. AMERICAN INDIAN/ALASKA NATIVE 4. ASIAN 5. NATIVE HAWAIIAN/PACIFIC ISLANDER

ARE YOU MARRIED AND LIVE WITH YOUR SPOUSE, OR LIVED WITH YOUR SPOUSE WHEN YOU ENTERED A NURSING HOME?

☐ YES ☐ NO

If yes, we need your spouse's income and resource information, but your spouse doesn't have to apply for coverage.

ENTER THE DATE YOU GOT MARRIED

SECTION 3: Money Available To You

ARE YOU OR YOUR SPOUSE A PARTY TO A TRUST?

☐ YES ☐ NO

If yes, we must review the entire trust. You must provide it and fill out below:

NAME AND DATE OF TRUST	WHAT IS YOUR OR YOUR SPOUSE'S ROLE IN THE TRUST?

I/We have the following resources (include trust assets you can access): Check (✓) all that apply.

CASH AND SECURITIES	OWNER	ACCOUNT #(S)	BANK/LOCATION	VALUE
☐ Checking Accounts/Joint Checking Accounts				$
☐ Savings accounts/Joint savings accounts, Christmas Club savings, certificates of deposit				$
☐ Credit union accounts				$
☐ Pre-paid card (other than EBT) **Example: card of Social Security income**				$
☐ Patient accounts at a nursing home or other institution				$
☐ Cash on hand		**N/A**		$
☐ Stocks, bonds, IRAs, retirement plans, other investments				$
☐ Annuities (We will need the whole contract)				$
☐ Notes or mortgages owed to you				$

PRE-PAID BURIAL PLAN

I/WE OWN 1 OR MORE PRE-PAID BURIAL PLANS

☐ YES ☐ NO

If yes, fill out below.

NAME OF INSURED	FUNERAL HOME	POLICY/CONTRACT #	CASH SURRENDER VALUE	REVOCABLE OR REFUNDABLE?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

SECTION 4: Your Income and Expenses

I/We receive income from the following. Check (✓) all that apply.

UNEARNED INCOME	WHO GETS IT?	WHERE IS IT FROM?	AMOUNT PER MONTH
☐ Social Security Claim number:		N/A	$
☐ Supplemental Security Income (SSI)		N/A	$
☐ Trusts and Annuities			$
☐ Non-VA pensions, Retirement, and Disability			$
☐ Interest or Dividends			$
☐ Unemployment compensation			$
☐ Worker's compensation			$
☐ Military branch retirement pension			$
☐ Worker's compensation			$
☐ Money from friends or family			$
☐ VA Payments (Check all that apply) ☐ VA Pension ☐ Disability Compensation ☐ DIC Compensation ☐ Aid & Attendance ☐ Homebound Allowance ☐ Medical Reimbursement		N/A	$ $ $ $ $ $ $ $
☐ Other (explain where the money comes from and the amount)			

EARNED INCOME	EMPLOYER	INCOME BEFORE TAXES	HOW OFTEN ARE YOU PAID THIS AMOUNT? (CHECK ONE)
☐ I am employed			☐ WEEKLY ☐ EVERY 2 WEEKS ☐ TWICE A MONTH ☐ MONTHLY
☐ My spouse is employed			☐ WEEKLY ☐ EVERY 2 WEEKS ☐ TWICE A MONTH ☐ MONTHLY
☐ _____ is employed			☐ WEEKLY ☐ EVERY 2 WEEKS ☐ TWICE A MONTH ☐ MONTHLY

SELF-EMPLOYMENT	WHO IS SELF-EMPLOYED?	TYPE OF BUSINESS	MONTHLY INCOME AFTER TAXES & EXPENSES
☐ Someone in my house or I am self-employed			$

FILL OUT THIS SECTION ONLY IF YOU'RE MARRIED AND LIVING IN A NURSING HOME

My spouse and I pay these costs

TYPE OF COST	AMOUNT	HOW OFTEN DO YOU PAY FOR IT?
☐ Utilities (not including phone)	$	
☐ Mortgage	$	
☐ Rent	$	
☐ Real Estate Taxes	$	
☐ Homeowner's Insurance	$	
☐ Condo Fees	$	
☐ Phone	$	

FILL OUT THIS SECTION IF YOU PAY ANY CHILD SUPPORT OR ALIMONY PAYMENTS

CASE NUMBER	AMOUNT PER MONTH	WHAT STATE DOES THE ORDER COME FROM?
	$	
	$	
	$	

SECTION 5: Your Citizenship and Residency

1. I/WE ARE RESIDENTS OF MISSOURI AND PLAN TO STAY IN MISSOURI
☐ YES ☐ NO

2. ALL APPLICANTS ARE U.S. CITIZENS
☐ YES ☐ NO If no, fill out the following:

NAME OF NON-CITIZEN APPLICANT	IMMIGRATION STATUS	REGISTRATION NUMBER	DATE OF ENTRY

3. I/WE AGREE TO APPLY FOR OTHER BENEFITS I/WE MAY BE ABLE TO GET (RSDI, SSI, VA, ETC)
☐ YES ☐ NO If no, you may not be able to get MO HealthNet.

SECTION 6: Your Personal Property

TRANSFER OF PROPERTY OR MONEY

HAS ANYONE IN YOUR HOME SOLD OR GIVEN AWAY MONEY, VEHICLES, OR PROPERTY WITHIN THE LAST FIVE YEARS?
☐ YES ☐ NO If yes, fill out below:

MONEY/VEHICLE/PROPERTY SOLD OR GIVEN	DATES SOLD OR GIVEN
PERSON IT WAS SOLD OR GIVEN TO	REASON
VALUE OF MONEY/VEHICLE/PROPERTY $	AMOUNT RECEIVED $

VEHICLES

List cars, trucks, vans, motorcycles, recreational vehicles, and others. ☐ I/We don't own a vehicle.

MAKE/MODEL	YEAR	OWNER	VALUE	AMOUNT OWED	HOW IS IT USED?
			$	$	
			$	$	
			$	$	

REAL ESTATE PROPERTY

I/WE OWN OR ARE BUYING REAL ESTATE.
☐ YES ☐ NO If yes, provide a copy of the deed

ENTER THE ADDRESS OR LOCATION (for mobile homes, see personal property below)	OWNER	VALUE	AMOUNT OWED	HOW IS IT USED? (home, rental, acreage, other)
		$	$	
		$	$	
		$	$	

PERSONAL PROPERTY

I/We own the following types of personal property (include trust assets that you have access to). Check (✓) all that apply.

TYPE OF PROPERTY	HOW MANY?	DESCRIPTION	VALUE	AMOUNT YOU OWE
☐ Mobile Home ☐ Check here if this is your home			$	$
☐ Farm machinery (include tractors)			$	$
☐ Farm livestock			$	$
☐ Farm grain or produce in storage			$	$
☐ Business equipment			$	$
☐ Trailer (utility, boat, etc.)			$	$
☐ Boat			$	$

☐ Aircraft			$	$
☐ Property claims in Probate Court			$	$
☐ Other (explain)			$	$

SECTION 7: Your Insurance

I/WE HAVE LIFE INSURANCE

☐ YES ☐ NO If yes, fill out below:

PERSON INSURED	INSURANCE COMPANY	POLICY NUMBER	CASH VALUE
			$
			$
			$

I/WE HAVE MEDICARE

☐ YES ☐ NO

If yes, list the names of the people who have Medicare:

I/WE HAVE LONG-TERM CARE INSURANCE

☐ YES ☐ NO If yes, fill out below:

NAME OF PERSON WITH LONG-TERM CARE INSURANCE	INSURANCE COMPANY	POLICY NUMBER	PREMIUM (per month)
			$
			$

I/WE HAVE OTHER HEALTH INSURANCE

☐ YES ☐ NO If yes, fill out below:

PERSON INSURED	INSURANCE COMPANY	TYPE OF COVERAGE	POLICY NUMBER	PREMIUM (per month)
				$
				$

IF YOU CAN GET CASH PAYMENTS AND HAVE AN ACCOUNT, DO YOU WANT THE CASH TO GO DIRECTLY INTO YOUR ACCOUNT?

☐ YES, I WANT DIRECT DEPOSIT ☐ NO, I DO NOT WANT DIRECT DEPOSIT.

Only fill out this section (Section 8) if you want Blind Pension or Supplemental Aid to the Blind.

SECTION 8: Blind Pension and Supplemental Aid to the Blind

1. Do you have a sighted spouse or parent? ☐ YES ☐ NO
2. Do you ask or beg for money? ☐ YES ☐ NO
3. Have you applied or do you agree to apply for Supplemental Security Income (SSI) as a condition of eligibility? ☐ YES ☐ NO
4. Have you had eye surgery within the last five years? ☐ YES ☐ NO
5. If you are younger than 75, are you willing to have medical treatment or an operation to correct your blindness? ☐ YES ☐ NO
6. Would you be willing to do job training or work at a job for which you are suited? ☐ YES ☐ NO
7. Do you have an eye doctor (either an opthalmologist or an optometrist)? ☐ YES ☐ NO
   If yes, fill out below:

FACILITY AND DOCTOR NAME	
ADDRESS (HOUSE NUMBER, STREET OR RURAL ROUTE, PO BOX)	CITY, STATE, ZIP CODE
DATE OF LAST EYE EXAM	DATE OF NEXT APPOINTMENT

RIGHTS AND RESPONSIBILITIES: PLEASE READ CAREFULLY AND SIGN BELOW

I/We understand that it is against the law to obtain or attempt to obtain benefits to which I/we are not entitled. Any false claim, statement or concealment of any material fact whatever, in whole or in part, may subject me to criminal and/or civil prosecution.

I/We authorize the Director of Family Support Division or his/her appointee to investigate and verify 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 understand that I/we must provide Social Security Numbers (SSN) of all persons applying for MO HealthNet. The SSN is used to determine eligibility and verify information (Section 1137 of the Social Security Act).

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 Medicare 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 hereby authorize all providers of medical benefits who render services or merchandise to me/us under MO HealthNet to release all records regarding such services or merchandise to the Department of Social Services and its representatives.

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 XVIII medical insurance program to be made directly to physicians and medical suppliers on any future covered unpaid bills for medical and other health services furnished me/us while eligible for MO HealthNet.

If signing electronically: By entering my name, I have agreed to submit this application by electronic means. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

By signing this application on paper or electronically, 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 on Page 2. You do not have to consent to this as part of your application. If you want to opt out of getting these calls, check here: ☐

My/Our signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF SPOUSE	DATE

SIGNATURE ON BEHALF OF APPLICANT	DATE

IF YOU ARE SIGNING ON THE APPLICANT'S BEHALF, PLEASE IDENTIFY YOUR RELATIONSHIP TO THE APPLICANT:

☐ Guardian or Conservator ☐ POA/Attorney-in-fact ☐ Estate representative

☐ Authorized representative (complete form IM-6AR in Appendix C) ☐ Family member

☐ Attorney representing applicant (please provide Entry of Appearance)

Please print your name and contact information below.

REPRESENTATIVE NAME (FIRST, MIDDLE, LAST)	
REPRESENTATIVE MAILING ADDRESS	CITY, STATE, ZIP CODE

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