MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MEDICAID APPLICATION/ELIGIBILITY STATEMENT

FOR OFFICE USE ONLY	
DATE APPLIED	
DCN #1	DCN #2
ELIGIBILITY SPECIALIST/SUPV/LOAD	

- ☐ QUALIFIED MEDICARE BENEFICIARY
- ☐ SPECIFIED LOW INCOME MEDICARE BENEFICIARY
- ☐ SUPPLEMENTAL NURSING CARE
- ☐ BLIND PENSION
- ☐ SUPPLEMENTAL AID TO THE BLIND
- ☐ MEDICAL ASSISTANCE
- ☐ SPENDDOWN
- ☐ NON-SPENDDOWN
- ☐ VENDOR

APPLICANT NAME (FIRST, MIDDLE, LAST)

ADDRESS (HOUSE NO., STREET OR RURAL ROUTE, PO BOX)	CITY, STATE, ZIP CODE

HOME PHONE NUMBER	WORK PHONE NUMBER	MESSAGE PHONE NUMBER

I, the above named applicant, under the laws of the state of Missouri, hereby apply for:

- ☐ Medical Assistance
- ☐ Nursing Home Assistance
- ☐ Payment of Medicare Premiums
- ☐ Cash Assistance for the Blind

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 (SPOUSE, SON, SISTER, FRIEND)	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	CHECK (✓) FOR WHOM APPLYING
			SELF				

* 1. CAUCASIAN 2. BLACK/AFRICAN AMERICAN 4. AMERICAN INDIAN/ALASKA NATIVE 5. ASIAN 6. NATIVE HAWAIIAN/PACIFIC ISLANDER

1. **Are all of the persons applying U.S. citizens?** ☐ YES ☐ NO If no, list the following information for applicants listed above who are not U.S. citizens: Name, immigration status, registration number, and date of entry: _____

2. **I/We are residents of Missouri and intend to remain.** ☐ YES ☐ NO

3. **The reason I/we are applying check (✓) all that apply.**
   - ☐ Age 65 or over ☐ Blind ☐ Disabled ☐ Unable to work due to a physical or mental illness
   - ☐ I/We need help paying my/our Medicare premiums.
   - ☐ I reside in or plan to enter a nursing home/facility.

4. **If you are a resident of a nursing facility and wish to give part of your income to your spouse or a dependent relative, list the name(s):** _____

5. **Are you living in or supported by a public, medical, or private facility?** ☐ YES ☐ NO

   Facility Name _____

6. **You may qualify for coverage of unpaid bills for medical services received in the past three months. Would you like for us to explore your eligibility for the last three months?** ☐ YES ☐ NO

COMPLETE THIS SECTION IF YOU ARE UNDER AGE 65 AND NOT RECEIVING SOCIAL SECURITY DISABILITY AND/OR SUPPLEMENTAL SECURITY INCOME. PLEASE LIST ALL SOURCES YOU WISH CONTACTED TO PROVIDE A FULL AND ACCURATE STATEMENT OF YOUR MEDICAL HISTORY AND CONDITION.

DOCTORS, HOSPITALS, CLINICS, OTHER

NAME	ADDRESS
NAME	ADDRESS

7. Have you or your spouse ever served in the U.S. Military? ☐ YES ☐ NO

EMPLOYMENT

1. Are you now employed? ☐ YES ☐ NO

If yes, name of employer _____

Amount you are paid before deductions $_____ ☐ Weekly ☐ Every 2 weeks ☐ Twice monthly ☐ Monthly

2. Is anyone else in your home employed? ☐ YES ☐ NO

If yes, who? _____

Amount they are paid before deductions $_____ ☐ Weekly ☐ Every 2 weeks ☐ Twice monthly ☐ Monthly

3. Does anyone in your home operate their own business or are they otherwise self-employed? ☐ YES ☐ NO

If yes, list who, describe what type of self-employment (baby-sitting, farm income, other) and amount earned: _____

_____

_____

_____

OTHER INCOME

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

	RECEIVED BY	SOCIAL SECURITY CLAIM NUMBER	AMOUNT PER MONTH
☐ Social Security			
☐ Supplemental Security Income			
☐ Trust Funds/Annuities			
☐ Pensions/Retirement/Disability			
☐ Interest or Dividends			
☐ Veteran's Benefits			
☐ Unemployment Compensation			
☐ Assistance from friends or relatives			

☐ Other: Explain where the money comes from and the amount.

INSURANCE

I/We have Medicare. ☐ **YES** ☐ **NO** If yes, list name(s) _____

I/We have other health insurance. ☐ **YES** ☐ **NO** If yes, complete the following:

PERSON INSURED	INSURANCE COMPANY	POLICY NUMBER	TYPE OF COVERAGE

I/We have life insurance and/or burial plans. ☐ YES ☐ NO If yes, complete the following:

PERSON INSURED	POLICY OWNER	CHECK (✓) KIND		INSURANCE COMPANY	POLICY NUMBER	FACE VALUE	CASH VALUE
		LIFE	BURIAL				

I/We have the following cash, securities, or personal property. Check (✓) all that apply.

CASH AND SECURITIES	IN WHOSE NAME	LOCATION	VALUE
☐ Checking Accounts/Joint Checking Accounts Account Numbers:			
☐ Savings Accounts/Joint Savings Accounts, Christmas Club Savings, Certificates of Deposit, Credit Union, IRA, Deferred Compensation Account Numbers:			
☐ Patient accounts at a nursing home or other institution			
☐ Cash on hand			
☐ Stocks, bonds, or other investments			
☐ Notes or mortgages owed to you			
☐ Property held in Safe Deposit Box (state location and contents of box).			

PERSONAL PROPERTY	LOCATION	VALUE	DEBT
☐ Burial lots			
☐ Household furniture (not in use)			
☐ Housetrailer (mobile home)			
☐ Jewelry (other than wedding and engagement rings, watches, or costume jewelry)			
☐ Business equipment			
☐ Farm machinery, livestock, grain and/or produce			
☐ Property claims in Probate Court			
☐ Other (explain)			

VEHICLES - LIST CARS, TRUCKS, VANS, MOTORCYCLES, RECREATIONAL VEHICLES, AND OTHERS

MAKE/MODEL	YEAR	OWNER	VALUE	DEBT	HOW IS IT USED?

REAL PROPERTY

I/We own or are buying real estate. ☐ YES ☐ NO

LIST KIND AND LOCATION	WHOSE NAME IS ON THE DEED?	CURRENT VALUE	AMOUNT OWED	HOW IS IT USED? (HOME, RENTAL, ACREAGE, OTHER)

TRANSFER OF PROPERTY RESOURCES

1. **Has anyone in your home sold or given away any money, vehicles, property, or any other resources within the last five years?**
   ☐ YES ☐ NO If yes, complete the following:

   What? _____ When? _____

   To whom? _____ Why? _____

   Amount received $ _____

2. **Have your or your spouse created, or been a party of, a Trust Estate within the last five years?** ☐ YES ☐ NO

   If yes, explain _____

COMPLETE IF APPLYING FOR CASH ASSISTANCE FOR THE BLIND

1. **Do you have a sighted spouse or parent?** ☐ YES ☐ NO
2. **Do you solicit alms?** ☐ 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 under age 75, are you willing to have medical treatment or an operation to correct blindness?** ☐ YES ☐ NO
6. **If recommended, are you willing to accept vocational training or work at an occupation for which you are suited?** ☐ YES ☐ NO

If you have a checking or savings account you can have your cash assistance deposited directly into your account.

☐ I want direct deposit. ☐ I do not want direct deposit.

PLEASE READ CAREFULLY AND SIGN BELOW

I/We UNDERSTAND that I/we are entitled to fair and equal treatment regardless of age, sex, race, color, handicap, religion, creed, national origin, or political belief.

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 provide Social Security Numbers (SSN) of all persons applying for Medicaid. The SSN is used to determine eligibility and verify information (Section 1137 of the Social Security Act).

I/We authorize the Director of Family Support Division or his/her appointee to investigate and verify these circumstances and statements.

I/We UNDERSTAND that I/we must report any changes in circumstances within ten days of when they happen.

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/us to criminal and/or civil prosecution.

I/We UNDERSTAND that the State of Missouri may file a claim against my/our estate to recover any assistance received.

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 Medicaid 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 Medicaid constitutes an assignment of rights to the Department of Social Services, Division of Medical Services, 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 Division of Medical Services 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 Medicaid.

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/AFFIDAVIT	DATE	SIGNATURE OF SPOUSE/AFFIDAVIT	DATE