MISSOURI
DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

CASE NUMBER:
COUNTY :

Senate Bill 539 (2005) eliminated the Medical Assistance for Workers with Disabilities (MA-WD) program, effective September 1, 2005. In order to determine continued eligibility under another program, we are asking that you complete the enclosed MA-WD investigation form.

After you have completed the form, please sign on the line indicated for SIGNATURE.

Please complete the form today and return it in the enclosed envelope by .
If any other forms are attached, please complete and sign these also and return them with the form.

Failure to return the form will result in your case being closed and not reviewed for potential eligibility for another Medicaid program.

If you have any questions, contact your caseworker.

Sincerely,

Caseworker:
Load Number:
Phone Number:

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI FAMILY SUPPORT DIVISION

MEDICAL ASSISTANCE FOR WORKERS WITH DISABILITIES

FSD OFFICE USE ONLY	DCN #1	DCN #2	CASELOAD #
	DATE LAST IM-2/2D	OFFICE VISIT ☐	DATE RECEIVED
		MAIL ☐	

CASE NAME	SOCIAL SECURITY NO.
SPOUSE'S NAME (if living in your home)	SOCIAL SECURITY NO.

ADDRESS		
CITY	STATE	ZIP CODE
HOME TELEPHONE NO.	ALTERNATE TELEPHONE NO.	

EARNED INCOME

Do you or your spouse receive **any** *earned* **income?** ☐ Yes ☐ No If yes, list below the amount of earned income **before** deductions. Provide verification.

NAME	EMPLOYER	RATE OF PAY	NUMBER OF HOURS	AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED

UNEARNED INCOME

Do you or your spouse receive **any** *unearned* **income?** ☐ Yes ☐ No If yes, check appropriate box(es) and list the amount you receive from each source you have checked.

	CLIENT	SPOUSE		CLIENT	SPOUSE
☐ Social Security	$ _____	$ _____	☐ Interest/Dividends	$ _____	$ _____
☐ VA	$ _____	$ _____	☐ Family/Friends	$ _____	$ _____
☐ Training Program	$ _____	$ _____	☐ Unemployment	$ _____	$ _____
☐ Trust Funds/Annuities	$ _____	$ _____	☐ SSI	$ _____	$ _____
☐ Other	$ _____	$ _____			

Are you age 63 or over and receive home health care or personal care services authorized by Senior Services (Department of Health and Senior Services? ☐ Yes ☐ No

Are you participating in the Section 1619(b) work incentive? ☐ Yes ☐ No Criteria is:

Eligible for an SSI cash payment for at least one month. You still meet the disability requirement, need Medicaid in order to work and have gross earned income which is insufficient to replace SSI, Medicaid and any publicly funded attendant care.

HEALTH INSURANCE

List any medical, hospital, or Medicare insurance you or your spouse may own or have dropped since your last reinvestigation.

INSURANCE NAME/KIND	PREMIUM AMOUNT	HOW OFTEN PAID	DATE STARTED, STOPPED OR CHANGED

RESOURCES

List any real property you or your spouse own or are buying other than your home.

TYPE OF PROPERTY/USE	IN WHOSE NAME	VALUE	DATE ACQUIRED	HOW ACQUIRED (bought, received as gift, inherited, etc.)

Do you or your spouse own any other assets or personal property? ☐ **Yes** ☐ **No**
Check (X) all that apply.

TYPE OF PROPERTY	IN WHOSE NAME	CURRENT VALUE
☐ Checking accounts/joint checking accounts Account numbers:		
☐ Savings accounts/joint savings account, certificates of deposit, IRA Account numbers:		
☐ Cash on hand, annuities, stocks, bonds, trust funds		
☐ Family development accounts, independent development accounts		
☐ OTHER (LIST)		

I hereby authorize the Department of Social Services, through the Director of Family Support or their appointee, to investigate these circumstances and statements.

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

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 or the United States.

SIGNATURE (OR MARK)	**DATE**
X	