STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MC+/MEDICAID ELIGIBILITY REINVESTIGATION INFORMATION

We are required to complete an annual review of MC+/Medicaid eligibility. In order to determine your family's continued eligibility, we are asking you to complete all questions on the enclosed form. Race and ethnic group information is only for statistical use and is optional. The Social Security Number is required only for persons who are receiving or applying for MC+/Medicaid coverage.

Please read each item carefully before you answer it. The answers you give will be used to determine continued eligibility for MC+/Medicaid coverage. If you need assistance in completing the form, or have any questions, questions, please contact your Eligibility Specialist.

After you have completed the form, please sign on the line indicated "Signature/Affidavit". The second parent or spouse must also sign the form if they physically reside in the home or if you practice joint custody for children receiving or applying for benefits. Return the form by _____ to your local Family Support Division office.

Please include proof of your household income such as a month of your most recent paycheck stubs, letter from your employer, or copies of your latest tax return if self-employed. These documents will be returned to you at your request.

Failure to return this form may result in MC+/Medicaid coverage being canceled. Contact your Eligibility Specialist if you have any questions.

Eligibility Specialist	Phone Number

Please see below for important information concerning eligibility for MC+/Medicaid coverage for parents or eligible caretakers and children.

For children to be eligible for MC+/Medicaid coverage, your family income must be below be below the amounts indicated, based on your family size

Maximum Monthly Income Per Family Size**				
Family Size	2	3	4	5
NO-COST Coverage	$1,712	$2,147	$2,582	$3,017
Monthly Premium *	$3,423	$4,293	$5,163	$6,033

* You will be notified of Premium amounts when approved for MC+/Medicaid. The monthly premium covers all eligible children in the household. Coverage does not begin until the premium payment is received by the Premium Collections Unit or 30 days after date of application if applicable.

For parents or eligible caretakers to be eligible for MC+/Medicaid coverage, the family's income (after allowable child care, child support income disregard, and work expense deductions) must be below the following amounts, based on family size:

Maximum Monthly Income Per Family Size**				
Family Size	2	3	4	5
MONTHLY INCOME	$234	$292	$342	$388

** Family size includes parents and children. Income amounts change annually in April.

Please keep this page. It contains important information.

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MC+/MEDICAID ELIGIBILITY REINVESTIGATION INFORMATION

Complete and return by:

Instructions: Please read each item carefully before you answer it. The answers you give will be used to determine continued eligibility for MC+/Medicaid. If you need assistance in completing the form, or have any questions, please contact your Eligibility Specialist. You must answer each question accurately and completely in ink. You may be required to provide verification of your statements. Attach an additional sheet if more space is needed in any section.

Head of Eligibility Unit	Supercase	DCN	
Street Address	City	State	ZIP
Current Phone	Work or Message Phone	Load Number	

LIST ALL MEMBERS OF THE HOUSEHOLD (List parents/guardians/yourself first. List stepparents and all children who live in your home.)

Name (First, Middle, Last) (Maiden)	Hispanic Y/N	Race*/ Sex	Relationship to Parent/Guardian	Birthdate	Social Security Number

* 1 White 2 Black/African American 4 American Indian/Alaska Native 5 Asian 6 Native Hawaiian/Pacific Islander

Are any of the above listed persons out of the home on a temporary basis? ☐ Yes ☐ No
If Yes, answer the following: Reason individual is out of home _____
Date individual left home _____ Date individual expected to return home _____
Current Address where individual resides _____
(If space is needed for additional individuals, please enter on page 6)

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

Do you practice joint custody with the absent parent of any of the children listed above? ☐ Yes ☐ No
If Yes, complete the following:
Child: _____ Absent Parent(AP): _____ AP SSN: _____
Child: _____ Absent Parent(AP): _____ AP SSN: _____
Attach income verification for the absent parent listed.

Are both parents of all the children in the home? ☐ Yes ☐ No If No, list child(ren) and name absent parent(s).
Child: _____ Absent Parent: _____
Child: _____ Absent Parent: _____
(If space is needed for additional individuals, please enter on page 6)

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

Has there been any change in citizenship or immigration status for individuals currently receiving MC+/Medicaid?
☐ Yes ☐ No If Yes, list the individual whose status has changed with the current information in the blanks.

Name	Immigration Status	Registration Number	Date of Entry

Is anyone in the household pregnant? ☐ Yes ☐ No
If Yes, who: _____ Expected due date _____

Is anyone in the household blind or disabled? ☐ Yes ☐ No If Yes, who: _____

NET WORTH:

What is your household's net worth (Net worth is the value of everything you own minus any debt): $_____

Indicate property owned

☐ Yes ☐ No	Home and Adjoining Property
☐ Yes ☐ No	Other Real Property
☐ Yes ☐ No	Cash and Securities
☐ Yes ☐ No	Automobiles
☐ Yes ☐ No	Recreational Vehicles/Watercraft
☐ Yes ☐ No	Livestock, farm equipment, tools, etc
☐ Yes ☐ No	Other _____

INCOME AND EXPENSES: (Please include proof of your income such as paycheck stubs for the last 30 days, letter from your employer, copies of your latest tax return if self employed, or award letter for Social Security or pensions. At your request these documents will be returned to you.)

Is anyone in your household employed? ☐ Yes ☐ No If Yes, complete the following and attach verification.

NAME	EMPLOYER NAME	EMPLOYER PHONE	PAY RATE	PER*	CHECK DATE	DATE REC'D	GROSS INCOME	TIPS, ETC.

* Hour Day Week Every Two Weeks Twice Monthly Month

Does anyone in your household operate his/her own business or are otherwise self-employed? ☐ Yes ☐ No
If Yes, who: _____ If Yes, complete below and attach verification.

Describe the type of self-employment (babysitting, farm income, other) _____
Enter amount earned:_____ Per * ☐ Hour ☐ Day ☐ Week ☐ Every Two Weeks ☐ Twice monthly ☐ Month

Childcare costs may be allowable income deductions for families. Do you pay someone to care for your child while working? ☐ Yes ☐ No If Yes, complete below and attach verification.

NAME OF CHILD	AMOUNT PAID	HOW OFTEN**	LIST PERSON PAID	DOES PERSON PAID LIVE IN YOUR HOME?

** Hourly Daily Weekly Every Two Weeks Twice Monthly Monthly

Does anyone pay child support to a dependent outside the home? ☐ Yes ☐ No
If Yes, complete the following and attach verification:
Paid by: _____ Child: _____ Amount _____

Do you anticipate any changes in employers, hours worked or wages paid? ☐ Yes ☐ No
If Yes, explain: _____

Is there anyone who plans to go to work? ☐ Yes ☐ No If Yes, who: _____
Where: _____ When: _____

Do you or any other household member receive money from any of the following sources?

	YES	NO		YES	NO
Social Security			Union Funds or Pension Benefits		
Supplemental Security Income (SSI)			Insurance Settlements		
Alimony			Rent received from Land/Buildings		
Money from others (friends, relatives, etc)			Room and/or Board Received		
Veteran's Benefits			Armed Forces Allotment		
Worker's Compensation			Money from Sale of Property		
Unemployment Compensation			Interest from Savings / Checking Account		
Disability or Sick Benefits			Any other income Explain:		
Income from Training Program					

Has anyone recently applied for any of the above benefits? ☐ Yes ☐ No
If Yes, explain: _____

Does anyone in the household receive child support? ☐ Yes ☐ No

If Yes, complete following and attach verification:

Amount	PER*	NAME OF CHILD

* Hour Day Week Every Two Weeks Twice Monthly Month

HEALTH INSURANCE (other than MC+/Medicaid):

I / We have medical insurance. ☐ Yes ☐ No If Yes, complete the following:

Name of Insured	Name of Company	Policy Number	Policy Holder	Coverage Type (Doctor or Hospital) If limited, explain

Has anyone in your home lost or dropped health insurance since approval or last review? ☐ Yes ☐ No
If Yes, provide name(s), date, and reason coverage ended. _____

Is health insurance available for any member of your family through an employer or other group membership?
☐ Yes ☐ No If Yes, enter name of employer or group _____

Is the insurance available for: ☐ Self ☐ Spouse ☐ Children

How much is the premium for the children? $_____ per month
Please refer to the income guidelines sent with the reinvestigation form. If income and family size fall in the premium group and you do not have access to insurance through an employer or other group, submit 2 quotes from private insurance companies of what they would charge for medical coverage for all of your children

1. $_____ per month Name of Company _____
2. $_____ per month Name of Company _____

ADDITIONAL INFORMATION: (If additional room is needed for any question please enter information here - attach verification as requested)

_____

_____

_____

_____

_____

_____

_____

PLEASE READ CAREFULLY AND SIGN BELOW: (Signature of spouse in the home or absent parent, if practicing joint custody, is also required)

- I AGREE THAT I MUST PROVIDE Social Security Numbers for all persons applying for or receiving MC+/Medicaid as required by law. The Social Security Number is used to determine eligibility and verify information.
- I agree that my statements and information provided may be verified.
- I will report any changes in circumstances within TEN (10) DAYS of when they happen.
- I know it is against the law to obtain or attempt to obtain benefits to which I am not entitled. Any false claim, statement or concealment of any material fact whatsoever, in whole or in part, may subject me to criminal and/or civil prosecution.
- I agree that by applying for (and being determined eligible for) MC+/Medicaid for a child who is deprived of parental support, I have assigned all rights to support to the State of Missouri, and that I must cooperate in establishing paternity and obtaining medical support unless I have good cause.
- I agree medical information about me and/or my family can be released if needed to administer this program.
- Provided I am found to be eligible for MC+/Medicaid, I know the State of Missouri will pay for covered services on my behalf and agree the state may collect payments from any third party (i.e. insurance, estate, etc.) for services paid by the state.

My signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete to the best of my knowledge.

Signature/Affidavit	Date	Signature/Affidavit of Spouse	Date
Signature/Affidavit of Joint Custody Parent			**Date**