SPEND DOWN PAY-IN AUTOMATIC WITHDRAWAL AUTHORIZATION (START, CHANGE OR CANCEL)

Please allow 30 days after submitting this form for automatic withdrawal to start, change or cancel. If you are starting automatic withdrawal, continue to pay the monthly invoice you receive until the automatic withdrawal is effective. At the time it is effective, you will no longer receive a monthly invoice. The automatic withdrawal is taken out of your account for the following month; example, June withdrawal is taken out for July.

If you need assistance filling out this form, or to verify the effective date of your request, call the Fiscal Operations and Reporting Unit (FORU) at (877) 888-2811.

Start, Change or Cancel Automatic Withdrawal

Choose One:

☐ Start* I want the Missouri Department of Social Services to withdraw the Spend Down Pay-In from my account.

☐ Change* I want the Missouri Department of Social Services to change automatic withdrawal to the bank account below.

☐ Cancel I want to cancel the automatic withdrawal of the Spend Down Pay-In.

*** IMPORTANT:** Attach a voided personal check, savings deposit slip or a signed bank verification letter to the application form. Your name must be pre-printed on the check or savings deposit slip; starter, counter checks or bank statements are not acceptable. A bank verification letter must be signed by the bank and include your name as well as complete electronic routing and depositor account numbers. The bank verification letter must state it is for automatic withdrawal – not for a direct deposit.

Account Information

Choose One: ☐ Checking ☐ Savings	Name of Financial Institution	Financial Institution Phone Number		
Street Address of Financial Institution		City	State	Zip Code

Agreement to Start or Change Automatic Withdrawal

I hereby authorize the withdrawal of the Spend Down Pay-In on or around the 10th of each month from my checking or savings account with the financial institution indicated above. The automatic withdrawal will be taken out of my account for the following month; example June withdrawal is taken out for July. I understand that the Spend Down Pay-In amount will vary monthly based on family size and income, and I authorize the continued automatic withdrawals. Withdrawals will be made monthly unless I choose to cancel this agreement. I understand that the MO HealthNet Division will make reasonable effort to complete the automatic withdrawal request in a timely manner. I recognize that it is my responsibility to have the funds available in the account indicated above for the withdrawal of my monthly Spend Down Pay-In.

Signature of Participant	Date
Telephone Number of Bank Account Holder	

Participant Information

MO HealthNet ID #	Participant Name	Telephone Number
Signature of Individual Making Request		Date

Mail the Automatic Withdrawal Authorization form and your voided personal check, savings deposit slip or signed bank verification letter to:

MO HealthNet Division
FORU 2nd Floor
PO Box 1116
Jefferson City MO 65102-6500