



SUPPLEMENT – AGED, BLIND, AND DISABLED SUPPLEMENT

Complete this supplement if you are requesting health coverage for anyone through the aged, blind, disabled, or long-term care programs. If the person requesting coverage is under the age of 18, include their information as well as the information for any of their parents living in the home.

This supplement does NOT meet the requirements of an application. This is to be completed in addition to the Application for Health Coverage & Help Paying Costs (IM-1SSL) or a MO HealthNet application online or by phone.

STEP 1: To explore MO HealthNet for the Aged, Blind, and Disabled for you and/or your spouse, or a disabled child.

| Name | Date of birth | Social Security Number | DCN |
|------|---------------|------------------------|-----|
| | | | |
| | | | |

I/We are disabled or blind and get Social Security Disability or SSI. Yes No
 If yes, who? _____

I/We are disabled or blind and **DO NOT** get Social Security Disability or SSI. Yes No
 If yes, who? _____

I/We need help paying for Medicare premiums and co-insurance costs. Yes No
 If yes, who? _____

I/We have a conservator, guardian, attorney-in-fact, or someone who represents me/us. Yes No
 If yes, provide proof or complete Appointing an Authorized Representative (IM-6AR).

I/We agree to apply for other benefits I/we may be able to get (RSDI, SSI, VA, etc.). Yes No

Do you plan to continue living in Missouri? Yes No

For Home and Community Based Services (HCB), Vendor (nursing home), and Supplemental Nursing Care (SNC) applicants:

Do you or your spouse live in or plan to live in a nursing home or residential care facility? Yes No

If Yes, who? _____ Facility Name: _____ Date: _____

Facility Address: _____

Continue - For HCB, Vendor (nursing home), and SNC applicants:

My spouse and I pay for shelter expenses (monthly or say how often):

| | | | | | | | |
|--|----------|--|----------|-------------------------------------|----------|--------------------------------|----------|
| <input type="checkbox"/> Mortgage | \$ _____ | <input type="checkbox"/> Rent | \$ _____ | <input type="checkbox"/> Electric | \$ _____ | <input type="checkbox"/> Water | \$ _____ |
| <input type="checkbox"/> Homeowner's Insurance | \$ _____ | <input type="checkbox"/> Real Estate Taxes | \$ _____ | <input type="checkbox"/> Condo Fees | \$ _____ | <input type="checkbox"/> Phone | \$ _____ |

Are you or your spouse over age 63 and need in-home nursing care? Yes No

If Yes, who? _____

Do you or your spouse pay court ordered child support or alimony? Yes No

When did you and your spouse get married? (MM/DD/YYYY) _____

For Blind Pension and Supplemental Aid to the Blind applicants:

Is anyone blind or visually impaired and applying for Blind Pension or Supplemental Aid to the Blind (cash benefits)? Yes No

If Yes, who? _____

- Do you have a sighted spouse or parent? Yes No
- Do you ask or beg for money from the public? Yes No
- Have you applied or do you agree to apply for SSI as a condition of eligibility? Yes No
- Have you had eye surgery within the last 5 years? Yes No
- If you are younger than 75 years old, are you willing to have medical treatment or an operation to correct your blindness? Yes No
 Not under 75
- Would you be willing to do job training or work at a job for which you are suited? Yes No
- Do you have an eye doctor (either an ophthalmologist or an optometrist)? Yes No

Doctor's name _____ Phone number _____

Address _____

STEP 2: Assets - Fill out the info below to tell us about the things you and your spouse (if married) own, such as bank accounts, stocks, bonds, life insurance, real estate, and personal property.

Money & accounts

Do you or your spouse have money or accounts? If yes, fill out the information below. Yes No

Money may include cash that is in your possession, at home, or that someone else is holding for you.

Accounts may include:

- Checking or Savings - including online accounts, such as Ally or Chime
- Mobile payment accounts – including (but not limited to) Venmo, PayPal, CashApp, and Zelle
- Prepaid or direct deposit cards
- Annuities (submit copy)
- Stocks, bonds, investments
- Life insurance (with cash value)
- Cryptocurrency
- Trusts (submit copy)

| Who? | Type of Account | Name of Bank | Account Number | Balance |
|-------|-----------------|--------------|----------------|---------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Trusts

Are you or your spouse an owner or beneficiary of a trust? Yes No
If yes, we must review the entire trust. You must provide a complete copy, including any amendments.

Name and Date of the Trust: _____ What is your (or your spouse's) role in the trust?

Vehicles

Do you or your spouse own any vehicles? Yes No
If Yes, provide information below for all cars, trucks, recreational vehicles, watercraft, or other vehicles.

| Who? | Year, Make, Model | Estimated Value | Amount Owed | How is it used? (personal, business, home, recreation, other – explain) |
|-------|-------------------|-----------------|-------------|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Real Estate Property

Do you or your spouse own or are currently buying any real estate? Yes No
If Yes, provide information below for any houses, buildings, rental property, land/lots, or other property.

| Who? | What and Where? | Estimated Value | Amount Owed | How is it used? (home, rental, business, other – explain) |
|-------|-----------------|-----------------|-------------|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Other assets you own

Do you or your spouse own any other personal property? Yes No
If Yes, provide information below.

This may include:

- Mobile (trailer) Home
- Household furniture (in storage)
- Business equipment
- Livestock, grain, produce, farm equipment, tools, etc.

| Who? | What? | Estimated Value | Amount Owed | How is it used? (personal, business, other – explain) |
|-------|-------|-----------------|-------------|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Transfer of property or assets

Have you or your spouse sold or given away any money, vehicles, property or other assets in the last 5 years?
 Yes No

If yes, fill out the information below:

What? _____ To whom? _____
When? _____ Amount Received? _____
Why? _____

Life insurance and pre-paid burial plans

Do you or your spouse own a life insurance policy? Yes No

| Who? | Name of company | Policy number | Cash Value | Date it began | Irrevocable? |
|-------|-----------------|---------------|------------|---------------|--|
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you or your spouse own a prepaid burial policy? Yes No

| Who? | Name of company | Policy number | Cash Value | Date it began | Irrevocable? |
|-------|-----------------|---------------|------------|---------------|--|
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Health insurance

Do you or your spouse pay for health insurance or Medicare? Yes No

| Who? | Name of company | Type of coverage | Policy number | Premium amount and frequency |
|-------|-----------------|------------------|---------------|------------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Long-term care insurance

Do you or your spouse have long-term care insurance? Yes No

| Who? | Name of company | Policy number | Policy holder | Premium amount and frequency |
|-------|-----------------|---------------|---------------|------------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Additional Information

Return Information

Upload your document: Visit mydssupload.mo.gov to upload a copy of your document

Mail to: Family Support Division
PO BOX 2700
Jefferson City, MO 65102

Fax to: 573-526-9400