MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPLICATION FOR MEDICARE SAVINGS PROGRAMS

Missouri Department of SOCIAL SERVICES

INSTRUCTIONS: Read and answer each question completely and accurately. Attach additional pages as needed. If you are unable to complete this application, you may have someone else help you. If you have questions, contact Family Support Division (FSD) toll free at 855-373-4636.

Sign, date and return the application to FSD by:

- Uploading your application: Visit mydssupload.mo.gov to upload a copy of your completed application
- Mail to: Family Support Division, PO BOX 2700, Jefferson City, MO 65102
- Fax to: 573-526-9400

NOTE: This is **NOT** an application for Healthcare. If you want to apply for MO HealthNet or other assistance programs, go to http://mydss.mo.gov/ and select *Apply for Services* or visit an FSD office to request an application. To apply by phone for **MO HealthNet only** call 855-373-9994.

☐ I/WE hereby apply for payment of Medicare premiums.

APPLICANT NAME (FIRST, MIDDLE, LAST)		
HOME ADDRESS (HOUSE NO. AND STREET)	CITY, STATE, ZIP CODE	
MAILING ADDRESS (IF DIFFERENT THAN ABOVE)	CITY, STATE, ZIP CODE	
PRIMARY PHONE NUMBER	ALTERNATE PHONE NUMBER	EMAIL ADDRESS

COMPLETE THE FOLLOWING INFORMATION FOR YOU AND YOUR SPOUSE (IF MARRIED)

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	HISPANIC Y/N	RACE*/ SEX	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	DO YOU HAVE MEDICARE? Y/N

*1. WHITE/ CAUCASIAN 2. BLACK/AFRICAN AMERICAN 3. NO LONGER USED 4. AMERICAN INDIAN/ALASKA NATIVE 5. ASIAN 6. NATIVE HAWAIIAN/PACIFIC ISLANDER

Are you applying for Medicare Savings for your spouse, too? ☐ YES ☐ NO

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

Are all of the persons applying US citizens? ☐ YES ☐ NO If no, list the following information for applicants named above who are not US citizens: Name, immigration status, registration number, and date of entry:

Are you or your spouse now employed? ☐ YES ☐ NO

WHO IS EMPLOYED	EMPLOYER'S NAME	AMOUNT PAID BEFORE DEDUCTIONS	FREQUENCY

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 (babysitting, farm income, other), and amount earned:

I/We receive other income. ☐ YES ☐ NO

Other income may include:

Social Security	Supplemental Security Income (SSI)	Trust Funds	Annuities
Pensions/Retirement	Unemployment Compensation	Alimony	Veteran's Benefits
Disability	Interest/Dividends/Investments	Assistance from friends or relatives	Any other income not from a job or self-employment

RECEIVED BY	TYPE OF INCOME	CLAIM NUMBER	AMOUNT PER MONTH

ASSETS - List all assets owned by you or your spouse.

CASH AND ACCOUNTS - Include all checking accounts, savings accounts, certificates of deposit, annuities, cash on hand, stocks, bonds or other investments, notes or mortgages owed to you, property held in safe deposit boxes or any other resources.

CASH AND ASSETS	IN WHOSE NAME	ACCOUNT NUMBER	LOCATION	VALUE

PERSONAL PROPERTY - Include burial lots, business or farm equipment, jewelry (other than wedding and engagement rings, watches or costume jewelry), property claims in probate court, or other personal property.

PERSONAL PROPERTY	LOCATION	VALUE	DEBT

VEHICLES – Include cars, trucks, vans, motorcycles, recreational vehicles, and any other vehicles.

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

REAL ESTATE – Include any homes, buildings, land, or other real estate you or your spouse own or are buying.

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

LIFE INSURANCE AND/OR BURIAL PLANS – Include any life insurance policies that you or your spouse are a policy owner.

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

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

PERSON INSURED	INSURANCE COMPANY	POLICY NUMBER	TYPE OF COVERAGE	MONTHLY PREMIUM

PLEASE READ CAREFULLY AND SIGN BELOW

I/We UNDERSTAND that:

- I/we are entitled to fair and equal treatment regardless of race, color, national origin, sex, age, religion, disability, ancestry, genetic information, pregnancy, sexual orientation, or veteran status.
- If I/we disagree with the decision concerning our eligibility, I/we may request a fair hearing by contacting the FSD at myDSS.mo.gov, by phone, mail, or in person.This request must be received within 90 days of the eligibility decision.
- I/we must provide Social Security Numbers (SSN) of all persons applying for MO HealthNet. The SSN is used to determine eligibilityand verify information (Section 1137 of the Social Security Act).
- I/We authorize the Director of FSD or his/her appointee to investigate and verify these circumstances and statements.
- I/we must report any changes in circumstances within ten days of when they happen. Visit myDSS.mo.gov or call 855-373-4636 to report changes.
- 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 ofany material fact whatever, in whole or in part, may subject me to criminal and/or civil prosecution.
- I/we must provide complete information regarding any health or accident insurance benefit available to any household member andI/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 MO HealthNet to release all records regarding suchservices or merchandise to the Department of Social Services and its representatives.
- An application for and acceptance of MO HealthNet constitutes an assignment of rights to the Department of Social Services, MO HealthNet Division 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 MO HealthNet Division 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 MOHealthNet.

My/our signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete.

If signing electronically: I have agreed to submit this application by electronic means. I understand an electronic signature has the same legal effect and can be enforced in the same way as a written signature. ☐ I agree

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF SPOUSE	DATE

SAVE PRINT RESET