



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
FAMILY SUPPORT DIVISION  
**MO HEALTHNET APPLICATION ADDENDUM:  
REQUEST TO ADD CASH BENEFITS**



Participant's Name		DCN
Address (street name, apartment number)		
(City, State, ZIP code)		
Mailing address (if different than above)		
Home Phone Number	Other Phone Number.	
<p>I, the above named applicant, under the laws of the State of Missouri, hereby request the following CASH benefits in ADDITION to MO HealthNet medical coverage:</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"><span>Supplemental Aid to the Blind</span><span>Blind Pension</span><span>Supplemental Nursing Care</span></div>		
<p><b>If you checked Supplemental Aid to the Blind or Blind Pension, please answer the following:</b></p> <p>Do you have a current/valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have there been changes in your household composition, income, or resources since your last MO HealthNet application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list changes:</p> <div style="border-bottom: 1px solid black; height: 20px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-top: 5px;"></div>		
<ol style="list-style-type: none"><li>1. If you are married, can your spouse see? <input type="checkbox"/> Yes <input type="checkbox"/> No</li><li>2. Do your parent(s) live in Missouri? <input type="checkbox"/> Yes <input type="checkbox"/> No<ul style="list-style-type: none"><li>• If yes, can they see? <input type="checkbox"/> Yes <input type="checkbox"/> No</li></ul></li><li>3. Do you ask or beg for money? <input type="checkbox"/> Yes <input type="checkbox"/> No</li><li>4. Will you or have you applied for Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No<ul style="list-style-type: none"><li>• You must do this to get Supplemental Aid for the Blind or Blind Pension</li></ul></li><li>5. Have you had eye surgery in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</li><li>6. If you are younger than 75, are you willing to have medical treatment or surgery to fix your blindness? <input type="checkbox"/> Yes <input type="checkbox"/> No</li><li>7. Are you willing to train for and work at a job you can do? <input type="checkbox"/> Yes <input type="checkbox"/> No</li><li>8. Do you have an eye doctor (either ophthalmologist or optometrist)? <input type="checkbox"/> Yes <input type="checkbox"/> No</li></ol> <p>Your eye doctor's name: _____</p> <p>Where they practice: _____</p> <p>Address (street, city, state, zip) _____</p> <p>Date of your last eye exam: _____</p> <p>Date of your next appointment: _____</p> <p>If you get these benefits, do you want to have them put directly into your bank account? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>NOTE:</b> If you are approved for Cash Assistance for the Blind, this could reduce other types of benefits, such as Supplemental Nutrition Assistance Program (SNAP), and help from other agencies.</p>		

**If you checked Supplemental Nursing Care, please answer the following:**

I reside (or will reside) in one of the following:

☐ Residential Care Facility

☐ Assisted Living Facility

☐ Immediate or Skilled Nursing Facility

Facility Name and address: \_\_\_\_\_

I have lived there since: \_\_\_\_\_ **OR** I will begin living there on: \_\_\_\_\_

**Your rights and responsibilities regarding MO HealthNet cash benefits**

I understand that these cash benefits are **optional** and that I may apply for MO HealthNet medical coverage without requesting or receiving any of the above cash benefits.

Provided I am found to be eligible for assistance, I 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 while eligible for MO HealthNet.

I understand if I disagree with the decision concerning my eligibility, I may request a fair hearing by contacting the local Family Support office. This request must be received within 90 days of the eligibility decision.

I understand that I must report any changes in circumstances within ten days of when they happen. Go online to [myDSS.mo.gov](http://myDSS.mo.gov) and click on "Report a change" or call 855-373-4636 to report changes.

I understand that 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 authorize the Director of Family Support Division or their appointee to investigate and verify these circumstances and statements through the Family Support Division's databases, matching programs and agreements with federal, state, and local agencies and/or consumer reporting agencies.

My signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete. By signing this form, I am agreeing that everything I have put on it is true. If it is not true, I may get in legal trouble.

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

<b>SIGNATURE OF APPLICANT</b> →		DATE
<b>SIGNATURE OF SPOUSE</b> →		DATE
<b>WITNESS</b> →		DATE
<b>WITNESS</b> →		DATE

**Questions?** Contact our SAB/BP processing center: **866-877-8155**