MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MO HEALTHNET APPLICATION ADDENDUM: REQUEST TO ADD CASH BENEFITS

Missouri Department of Social Services

Important: This is NOT a MO HealthNet application.
This is an Addendum to add cash benefits to an active MO HealthNet case, or a pending MO HealthNet application.

Participant's First Name	Last Name	DCN or SSN

Address (street name)	Apt, Suite, or Trailer Number

City	State	Zip Code

Mailing address (if different than above)		

City	State	Zip Code

Home Phone Number	Other Phone Number.

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:

☐ Supplemental Aid to the Blind or Blind Pension (complete this page)

☐ Supplemental Nursing Care (continue to page 2)

If you checked Supplemental Aid to the Blind or Blind Pension, answer all the following:

Have there been changes in your household composition, income, or resources since your last MO HealthNet application? ☐ Yes ☐ No If yes, please state changes (attach additional pages if necessary):

_____

1. If you are married, can your spouse see? ☐ Yes ☐ No
2. Do your parent(s) live in Missouri? ☐ Yes ☐ No
   - If yes, can they see? ☐ Yes ☐ No
3. Do you ask or beg for money? ☐ Yes ☐ No
4. Will you or have you applied for Supplemental Security Income (SSI)? ☐ Yes ☐ No
   - You must do this to get Supplemental Aid for the Blind or Blind Pension
5. Have you had eye surgery in the past 5 years? ☐ Yes ☐ No
6. If you are younger than 75, are you willing to have medical treatment or surgery to fix your blindness? ☐ Yes ☐ No
7. Are you willing to train for and work at a job you can do? ☐ Yes ☐ No
8. Do you have an eye doctor (either ophthalmologist or optometrist)? ☐ Yes ☐ No

Your eye doctor's name: _____

Where they practice: _____

Address (street, city, state, zip) _____

Date of your last eye exam: _____

Date of your next appointment: _____

Note: 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.

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

Have there been changes in your household composition, income, or resources since your last MO HealthNet application? ☐ Yes ☐ No If yes, please state changes (attach additional pages if necessary):

_____

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

☐ Residential Care Facility	☐ Assisted Living Facility	☐ Intermediate or Skilled Nursing Facility

Facility Name:		**Base Rate:**	**$**
Address:	Street Address		
City	State	Zip Code	

Optional (all programs)

Optional: If you are a Veteran in the state of Missouri and are interested in learning more about benefits and resources available to you and your dependents, visit: https://mvc.dps.mo.gov/MoVeteransInformation/Survey/DSS

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.
- I/we understand that if I/we obtain or renew a driver license while receiving Blind Pension benefits I/we will be sanctioned from the Blind Pension program for 2 years, 4 years or permanently.
- I/we understand that if I/we operate a motor vehicle while receiving Blind Pension benefits I/we will be sanctioned from the Blind Pension program for 2 years, 4 years or permanently. I/we agree to provide Social Security Numbers of all persons applying for MO HealthNet as required by law. The Social Security Number is used to determine eligibility and verify information.
- I/we agree to be evaluated for the Health Insurance Premium Payment Program (HIPP) if I or members of the household are employed or lost employment in the last 30 days and the employer or former employer offers group health insurance.
- I/we authorize the Director of the Family Support Division or his/her appointee to investigate and verify these circumstances and statements through any means authorized by law, including accessing public and private databases.
- I/we will report any changes in circumstances within TEN DAYS of when they happen.
- I/we know it is against the law to obtain or attempt to obtain benefits to which I am/we are not entitled. Any false claim, statement, or concealment of any material fact whatsoever, in whole or in part, may subject me/us to criminal and/or civil prosecution.
- I/we understand 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.
- I/we agree that medical information about me and/or my family can be released if needed for treatment, payment of medical expenses, health care operations, and/or to administer this program.
- If I am/we are found to be eligible for MO HealthNet I/we know the state of Missouri will pay for covered services on my/our behalf and agree the state may file a claim against my/our estate to recover any assistance received.

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Continued: Your rights and responsibilities regarding MO HealthNet cash benefits

- If I think the Family Support Division has made a mistake, I can appeal its decision. To appeal means to tell someone at the Family Support Division that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by calling the Contact Center at 855-373-9994. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- If anyone on this application is eligible for MO HealthNet, I am giving to the Family Support Division our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting http://dss.mo.gov/files/missouri-nondiscrimination-policy-statement.htm
- By signing this application on paper or electronically, you are giving us permission to deliver, or cause to be delivered, automated phone calls and text messages regarding your case at the primary phone number you provided on page 1. You do not have to consent to this as a condition of eligibility. If you do not want to be contacted in this manner, you can opt out of getting these calls or messages.
  Check here: ☐ opt out calls ☐ opt out texts ☐ opt out calls and texts
- Required if signing electronically. By signing this application electronically, I certify under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my knowledge. 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

SIGNATURE OF APPLICANT		DATE
SIGNATURE OF SPOUSE		DATE
WITNESS		DATE
WITNESS		DATE

Questions? Contact Family Support Division online at myDSS.mo.gov or call us at 855-373-4636.

Return this Application Addendum:

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

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You may use this page for additional information.