MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MO HEALTHNET/GATEWAY TO BETTER HEALTH APPLICATION/ELIGIBILITY STATEMENT

FOR OFFICE USE ONLY	
DATE APPLIED	
DCN #1	DCN #2
ELIGIBILITY SPECIALIST - USER ID	
FACILITY - INTAKE WORKER	

The **Gateway To Better Health Program** provides basic health care needs. We must first determine if you are eligible for MO HealthNet and you will be notified by mail regarding the decision. This application will be used for both programs. Please answer all questions, read and acknowledge the last section. Then sign and date the application.

1. Tell Us About You

APPLICANT NAME (FIRST, MIDDLE, LAST)		
ADDRESS (HOUSE NO., STREET OR RURAL ROUTE, P. O. BOX)	CITY, STATE, ZIP CODE	
HOME PHONE NUMBER	WORK PHONE NUMBER	MESSAGE PHONE NUMBER

I, the above named applicant, under the laws of the state of Missouri, hereby apply for: MO HealthNet.
I understand that if I am not eligible for a MO HealthNet Program, I may be eligible for the Gateway To Better Health Program. If it looks like I may be eligible to get regular MO HealthNet, I may need to provide more information.

2. People In Your Home

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	HISPANIC Y/N	RACE*/ SEX	RELATIONSHIP (SPOUSE, SON, SISTER, FRIEND)	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	CHECK (✓) FOR WHOM APPLYING
			SELF				✓

1. WHITE/CAUCASIAN 2. BLACK/AFRICAN AMERICAN 3. AMERICAN INDIAN/ALASKA NATIVE 4. ASIAN 5. NATIVE HAWAIIAN/PACIFIC ISLANDER

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

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

3. I/We are residents of ☐ St. Louis County ☐ St. Louis City

4. Please read the definitions below and list anyone in your home (including yourself) that is disabled.
DISABLED is defined as the inability to engage in any substantial gainful activity by reason of any physical or mental impairment or combination of impairments that is expected to result in death or which has lasted or is expected to last for a continuous period of 12 months or more.
SUBSTANTIAL GAINFUL ACTIVITY (SGA) - A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount for 2019 is $1220.00

5. Is anyone in your household pregnant? ☐ YES ☐ NO If yes, who? Expected due date

3. Income

EMPLOYMENT

1. Are you now employed? ☐ Yes ☐ No

If yes, name of employer _____.

Amount you are paid before deductions $_____ ☐ Weekly ☐ Every 2 weeks ☐ Twice monthly ☐ Monthly

2. Is anyone else in your home employed? ☐ YES ☐ NO

If yes, who? _____.

Amount they are paid before deductions $ _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice Monthly ☐ Monthly

3. 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:

_____.

OTHER INCOME

I/We receive other income from the following. Check (✓) all that apply.

WHERE THE MONEY COMES FROM	WHO GETS THE MONEY	HOW OFTEN IS MONEY RECEIVED	AMOUNT
☐ Social Security			
☐ Supplemental Security Income			
☐ Trust Funds/Annuities			
☐ Pensions/Retirement/Disability			
☐ Interest or Dividends			
☐ Veteran's Benefits			
☐ Unemployment Compensation			
☐ Assistance from friends or relatives			

☐ Other: Explain where the money comes from and the amount.

4. Resources or Assets

I/We have the following cash, securities, or personal property. Check (✓) all that apply.

	CASH AND SECURITIES	IN WHOSE NAME	LOCATION	VALUE
☐	Checking Accounts/Joint Checking Accounts Account Numbers:			
☐	Savings Accounts/Joint Savings Accounts, Christmas Club Savings, Certificates of Deposit, Credit Union, IRA, Deferred Compensation Account Numbers:			
☐	Patient accounts at a nursing home or other institution			
☐	Cash on hand			
☐	Stocks, bonds, or other investments			
☐	Notes or mortgages owed to you			
☐	Property held in a Safe Deposit Box (state location and contents of box).			

5. Insurance

I/We have Medicare. ☐ YES ☐ NO If yes, list name(s) _____

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

PERSON INSURED	INSURANCE COMPANY	POLICY NUMBER	TYPE OF COVERAGE

The Gateway To Better Health Program offers limited benefits. Please mark your primary health center below.

☐	Affinia Healthcare
☐	Betty Jean Kerr Peoples Health Centers
☐	CareSTL Health
☐	Family Care Health Centers
☐	St. Louis County Health Department

PLEASE READ CAREFULLY AND SIGN BELOW

I/We UNDERSTAND that I/we are entitled to fair and equal treatment regardless of age, sex, race, color, handicap, religion, creed, national origin or political belief.

I/We UNDERSTAND if I/we disagree with the decision concerning our eligibility, I/we 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/We UNDERSTAND that I/we must provide Social Security Numbers (SSN) of all persons applying for MO HealthNet and Gateway To Better Health Programs. The SSN is used to determine eligibility and verify information (Section 1137 of the Social Security Act).

I/We authorize the Director of Family Support Division or his/her appointee to investigate and verify these circumstances and statements.

I/We UNDERSTAND that I/we must report any changes in circumstances within ten days of when they happen.

I/We UNDERSTAND that 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 of any material fact whatever, in whole or in part, may subject me to criminal and/or civil prosecution.

I/We UNDERSTAND that the State of Missouri may file a claim against my/our estate to recover any assistance received. This does not apply to Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary programs.

I/We UNDERSTAND that I/we must provide complete information regarding any health or accident insurance benefit available to any household member and I/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 such services or merchandise to the Department of Social Services and its representatives.

I/We UNDERSTAND that 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 MO HealthNet.

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

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF SPOUSE	DATE