MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MC+ ANNUAL REVIEW

FROM	ELIGIBILITY SPECIALIST	TELEPHONE NUMBER	DATE
	COUNTY OFFICE ADDRESS (STREET)		
	CITY, STATE, ZIP CODE		
TO	NAME		
	ADDRESS (STREET)		
	CITY, STATE, ZIP CODE		
RE	CASE NAME	CASE DCN	

Dear

We are required to do an annual review of MC+ healthcare eligibility. In order to determine your family's continued eligibility, we are asking you to complete **all** sections in the white areas of the attached form. Race and ethnic group information is only for statistical use and is optional. The Social Security Number is required only for persons applying for MC+ coverage.

Please read each item carefully before you answer it. The answers you give will be used to determine continued eligibility for MC+ healthcare coverage. If you need any assistance in completing the form, or have any questions, please contact your MC+ Service Representative.

After you have completed the form, please sign on the line indicated "parent/guardian" and return, in the attached envelope by _____ .

Please include proof of your income such as paycheck stubs for the last 30 days, employer statement, or copies of your latest tax return, if self-employed. At your request, these documents will be returned to you.

Failure to return this form may result in MC+ coverage being canceled.

Sincerely,

_____

Eligibility Specialist
Phone Number _____ - _____ - _____

For children to be eligible for MC+ healthcare coverage, your family income must be below the amounts indicated, based on your family size.

Maximum Monthly Income Per Family Size**				
What You Pay	**2**	**3**	**4**	**5**
NO-COST	$1,650	$2,075	$2,500	$2,925
Monthly Premium	$3,300	$4,150	$5,001	$5,850

***You will be notified of Premium amounts when approved. The monthly premium includes all eligible children in the household. Coverage does not begin until the premium payment is received by the Premium Collections Unit.**

For parents to be eligible for MC+ health coverage, the family's income (after allowable child care, child support income disregard, and work expense deductions) must be below the following amounts, based on family size:

Maximum Monthly Income Per Family Size**				
Family Size	**2**	**3**	**4**	**5**
MONTHLY INCOME	$234	$292	$342	$388

****Family size includes parents and children. Income amounts change annually in April.**

Please keep this page. It contains important information.

MISSOURI MC+ REVIEW

COMPLETE IN INK

NAME (FIRST, MIDDLE, LAST)			FOR OFFICE USE ONLY
			DATE RECEIVED
ADDRESS (HOUSE NO., STREET OR RURAL ROUTE, P.O. BOX NO.) CITY, STATE, ZIP CODE		COUNTY	DCN
HOME PHONE NUMBER	WORK PHONE NUMBER	MESSAGE PHONE NUMBER	ELIGIBILITY SPECIALIST/SUPV/LOAD

INSTRUCTIONS: Please answer each question completely. Attach an additional sheet if more space is needed in any section.

A. HOUSEHOLD INFORMATION (LIST ALL CHILDREN, PARENTS/GUARDIANS AND STEPPARENTS WHO LIVE IN YOUR HOME, YOURSELF FIRST.)

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	RACE*/ SEX	HISPANIC Y/N	RELATIONSHIP TO PERSON #1	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER
1.			SELF			
2.						
3.						
4.						
5.						
6.						

*(1 — White 2 — Black/African American 4 — American Indian/Alaskan Native 5 — Asian 6 — Native Hawaiian/Pacific Islander)

1. Do you wish to start coverage for any of the above persons who are not currently covered by MC+? ☐ YES ☐ NO

   If yes, who? _____

2. Are both parents of all the children in the home? ☐ YES ☐ NO If NO, complete section D.

3. Are all of the persons requesting MC+ U.S. citizens? ☐ YES ☐ NO If NO, list the following information for persons applying or receiving MC+ who are not U.S. citizens: Name, immigration status and registration number, date of entry:

   _____

   _____

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

5. Is your net worth (net worth is the value of everything you own minus any debt.): ☐ less than $50,000 ☐ $50,000 - $100,000 ☐ $100,000 - $150,000 ☐ $150,000 - $200,000 ☐ $200,000 - $250,000 ☐ above $250,000

   Please list your assets (bank accounts, stocks/bonds, vehicles, home, real and personal property, etc.) _____

   _____

B. INCOME (Please attach verification; i.e. paycheck stubs, note from employer, federal income tax return, award letter, etc.)

1. Are you employed? ☐ YES ☐ NO If YES, name of employer _____

   How much are you paid **before** taxes or deductions? _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly

2. Is anyone else in your home employed? ☐ YES ☐ NO If YES, who? _____

   Name of employer _____

   How much are they paid **before** taxes or deductions? _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly

3. Does anyone in your home operate their own business or are they otherwise self-employed? ☐ YES ☐ NO

   If YES, who? _____ Describe what type of self-employment (baby-sitting, farm income, other) and amount earned: _____ ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Yearly

4. Childcare costs may be an allowable income deduction for working families. Do you pay someone to care for your child?

   ☐ YES ☐ NO If YES, list names of child(ren) cared for: _____

   How much do you pay for child care? _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly

5. Does anyone in your home receive other income such as child support, alimony, Unemployment Compensation benefits, sick benefits, interest income, Social Security benefits, or other unearned income? ☐ YES ☐ NO If YES, complete the following:

PERSON RECEIVING	WHO PROVIDES THE MONEY?	AMOUNT RECEIVED	HOW OFTEN RECEIVED?

C. HEALTH INSURANCE

1. Does anyone in your home have medical, hospital insurance, or Medicare? ☐ YES ☐ NO If yes, list policies below.

PERSONS INSURED	NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
		☐ Doctor ☐ Hospital If limited coverage explain:
		☐ Doctor ☐ Hospital If limited coverage explain:

2. Has anyone in your home lost or dropped health insurance within the past six months? ☐ YES ☐ NO If yes, provide name(s), date and reason coverage ended. _____
3. Is health insurance available for any member of your family through an employer or other group membership? ☐ YES ☐ NO
   If yes, name of employer or group: _____
   Is the insurance available for: ☐ Self ☐ Spouse ☐ Children How much is the premium for the children? $ _____ per _____
4. Do any of your children have a medical condition that left untreated would result in the death or serious physical injury of the child?
   ☐ YES ☐ NO If yes, provide name(s) of child(ren) _____
5. Is a third party responsible to pay for any of your medical care? ☐ YES ☐ NO If yes, who? _____
6. Please refer to the income guidelines sent with the application. If income and family size fall in the premium group, submit 2 quotes from private insurance companies of what they would charge for medical coverage for all of your children.
   A. $ _____ per mo. Company _____ 2. B. $ _____ per mo. Company _____

D. ABSENT PARENT INFORMATION (Complete this section if a parent of any of the children is absent from the home.)

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	RACE/SEX	SOCIAL SECURITY NUMBER	BIRTHDATE	PARENT OF WHICH CHILD?	LAST KNOWN ADDRESS

1. Do you have any new information about an absent parent(s)? ☐ YES ☐ NO If YES, please give details.
   _____
   _____
2. Do you have a good reason for not cooperating in obtaining support for medical care? ☐ YES ☐ NO If YES, please explain.
   _____

E. PLEASE READ CAREFULLY AND SIGN BELOW

- I/we agree I/we must provide Social Security Numbers of all persons applying for MC+ as required by law. The Social Security Number is used to determine eligibility and verify information.
- I/we agree I/we must be evaluated for the Health Insurance Premium Payment Program (HIPP) if I/we 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 agree my/our statements and information provided may be verified.
- 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 whatever, in whole or in part, may subject me/us to criminal and/or civil prosecution.
- I/we agree by applying for (and being determined eligible for) MC+ for a child who is deprived of parental support, I/we have assigned all rights to medical support to the State of Missouri, and that I/we must cooperate in establishing paternity and obtaining medical support, **unless I/we have good cause.**
- I/we agree that medical information about me and/or my family can be released if needed to administer this program.
- Provided I am/we are found to be eligible for MC+ I/we know the State of Missouri will pay for covered services on my/our behalf and agree the state may collect payments from any third party (i.e., insurance, estate, etc.) for services paid by the state.
- I/we authorize insurers or employers to release any information on myself or my dependent(s) needed to determine eligibility for the HIPP Program.

My/our signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete to the best of my/our knowledge. I/we authorize insurers or employers to release any information on myself or my dependent(s) needed to determine eligibility for the HIPP program.

SIGNATURE/AFFIDAVIT	DATE	SIGNATURE OF SPOUSE/AFFIDAVIT	DATE