

**BCCT MO HEALTHNET APPLICATION**

|                  |
|------------------|
| SMHW PROVIDER    |
| TELEPHONE NUMBER |
| DIAGNOSIS DATE   |

| FOR OFFICE USE ONLY                  |   |
|--------------------------------------|---|
| DATE APPLIED                         |   |
| DCN                                  |   |
| <input type="checkbox"/> SERVICE REP | <input type="checkbox"/> SUPERVISOR <input type="checkbox"/> LOAD |

**COMPLETE IN INK**

| A. MAILING ADDRESS  |                       |                          |                        |             |
|---|-----------------------|--------------------------|------------------------|-------------|
| NAME (FIRST, MIDDLE, LAST)  | MAIDEN NAME           | DATE OF BIRTH            | SOCIAL SECURITY NUMBER | RACE/ETHNIC |
| ADDRESS (HOUSE NO., STREET, RURAL ROUTE, PO BOX NO) CITY, STATE, ZIP CODE, COUNTY |                       |                          |                        |             |
| HOME TELEPHONE NUMBER   | WORK TELEPHONE NUMBER | MESSAGE TELEPHONE NUMBER |                        |             |

**B. INSTRUCTIONS: Please answer each question completely.**

|   | YES   | NO                       |
|---|---|--------------------------|
| 1. Born in Missouri?  | <input type="checkbox"/>  | <input type="checkbox"/> |
| 2. Are you a U.S. citizen? If "NO", list immigration status and registration number, date of entry: | <input type="checkbox"/>  | <input type="checkbox"/> |
| 3. Do you currently have healthcare insurance?  | <input type="checkbox"/>  | <input type="checkbox"/> |
| NAME OF COMPANY AND POLICY NUMBER   | TYPE OF COVERAGE  |                          |
|   | <input type="checkbox"/> DOCTOR <input type="checkbox"/> HOSPITAL <b>If limited coverage explain:</b> |                          |
|   | YES   | NO                       |
| 4. Do you have children under the age of 19 residing in your home?                                  | <input type="checkbox"/>  | <input type="checkbox"/> |
| 5. Are you pregnant?  | <input type="checkbox"/>  | <input type="checkbox"/> |
| 6. Are you blind?   | <input type="checkbox"/>  | <input type="checkbox"/> |
| 7. Are you disabled?  | <input type="checkbox"/>  | <input type="checkbox"/> |

**C. PLEASE READ CAREFULLY AND SIGN BELOW:**

- I 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 agree that my statements and information provided may be verified.
- I will report any changes in circumstances within **TEN DAYS** of when they happen.
- I know that it is against the law 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 agree that medical information about me can be released if needed to administer this program.
- I understand Healthcare benefits based on a person being blind, disabled, age 65 or over, pregnant women, child or parent, is not determined by completing this application. If I want eligibility for healthcare benefits explored on the basis of one of these, I must complete a different application for these benefits.
- Provided I am found to be eligible for MO HealthNet, I know the state of Missouri will pay for covered services on my behalf and agree the state may collect payments from any third party (i.e., insurance, estate, etc.) for services paid by the state.
- I understand that if I disagree with the decision concerning my eligibility, I may request a fair hearing within 90 days of the date of the decision.

**I agree that the 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 knowledge.**

|           |      |
|-----------|------|
| SIGNATURE | DATE |
|-----------|------|

**CALL 1-888-275-5908 IF YOU HAVE ANY QUESTIONS.**