



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

NOTICE OF ELIGIBILITY FOR NURSING FACILITY AND OTHER VENDOR SERVICES

FROM	COUNTY OFFICE NAME	TELEPHONE NUMBER	DATE
	ADDRESS (NUMBER AND STREET, CITY, ZIP CODE) _____		
TO	NAME		CASE NUMBER
	ADDRESS (STREET)		
	CITY	STATE	ZIP CODE
RE	VENDOR NAME		
	VENDOR NUMBER		

Effective _____ you (are continue to be) eligible for vendor payments made in your behalf for the following type of care:

- | | |
|---|--|
| <input type="checkbox"/> nursing facility | <input type="checkbox"/> institution for the mentally retarded |
| <input type="checkbox"/> mental hospital | <input type="checkbox"/> psychiatric services |

Your eligibility ends _____ because you may have a mental health service need and you were admitted under a special category.

Because payment for your care will be made directly to the nursing home or institution, your cash grant of \$ _____ has been stopped.

A study of your income indicates that you must make the following "surplus" payments to the nursing home or institution.

MONTH, DAY, YEAR	YOUR MONTHLY PAYMENT IS
AS OF _____	\$ _____
AS OF _____	\$ _____
AS OF _____	\$ _____

These amounts vary because: _____

You are not required to pay for a particular month if Medicare covers some or all charges for each day in that month. Report to your County Family Services Office any months for which you do not have to pay.

In addition to the above amounts, the nursing home or institution may charge you or your relatives for services not covered by Medicaid.

Any increase, decrease, or other change in your income may change the amount you must pay to the nursing home or institution. Any increase in your resources may affect your eligibility. **You must report any change in your situation to your County Family Services Office immediately.** If you fail to give full information about your situation or if you receive benefits for which you are not eligible through misrepresentation, legal action can be taken against you.

Enclosed is a leaflet which contains important information about your medical benefits. Please read it carefully and keep it for future reference.

If you feel this decision is not correct, you have the right to request a hearing within 90 days of the date of this letter.

If you wish to have a hearing, you may advise us of this by mail, by telephone, or in person. We will then schedule a hearing for you and notify you of the time of the hearing. If you request a hearing, you may present your information yourself or you may be represented by your own attorney or by other persons who have knowledge of your situation. If you do not have an attorney, cannot afford one, and live in an area served by a legal aid or legal services office, you may be eligible for this service. You have the right to present witnesses in your own behalf and to question witnesses who appear at the request of the Division of Family Services.

ENCLOSURE

cc: VENDOR
RELATIVE

CASEWORKER SIGNATURE	LOAD NUMBER
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DETERMINATION OF MONTHLY PAYMENT TO NURSING HOME/INSTITUTION

GROSS MONTHLY INCOME

MONTHLY DEDUCTIONS

Social Security	
SSI	
VA	
Interest	
Earned	
Other	
TOTAL	

Personal Needs Allowance	
Medicare Premium	
Other Medical Insurance	
*Allotment for Spouse	
Allotment for other Dependents	
TOTAL	

*This is the amount you are currently giving your spouse. If your income increases, you may give your spouse up to \$ _____ monthly.

Your total gross monthly income less your total monthly expenses leaves a "surplus" amount of \$ _____.
The "surplus" is your payment to the nursing home or institution.

THIS NOTICE WILL ALSO SERVE TO VERIFY ELIGIBILITY FOR MEDICAL SERVICES UNTIL THE REGULAR MEDICAID CARD IS RECEIVED.

ELIGIBLE FOR MEDICAID (TITLE XIX) BENEFITS

LOCK IN CASE YES NO

QMB	NAME			MEDICAID NO.	PERIOD OF COVERAGE*	
	(LAST)	(FIRST)	(MIDDLE)		FROM	TO

*Period of coverage includes the Prior Quarter: Yes No. You are not eligible for prior quarter coverage because _____

TO THE VENDOR:

QUALIFIED MEDICARE BENEFICIARIES: Persons with a "Y" indicator in the QMB field are eligible for benefits in addition to regular Medicaid, which include Medicare covered services. Total Medicaid payment for Medicare covered services will consist of co-insurance and deductible amounts, as determined by the Medicare program.

MEDICAID-LOCK-IN PROGRAM	THIRD PARTY LIABILITY	
<input type="checkbox"/> PHYSICIAN	<input type="checkbox"/> PHARMACY	<input type="checkbox"/> OPTOMETRIST
<input type="checkbox"/> DENTIST	<input type="checkbox"/> PODIATRY	<input type="checkbox"/> O.P.-E.R. FACILITY
NAME	NAME:	INS. CODE:
ADDRESS	INS. CO.:	INS. CODE:
NAME	NAME:	INS. CODE:
ADDRESS	INS. CO.:	INS. CODE: