Introduction

The MoKP Facility Guidelines Manual delineates the official Missouri Kidney Program (MoKP) policies and procedures, approved by the MoKP advisory council and staff, which govern the end-stage renal disease (ESRD) programs and assistance administered by the University of Missouri-Columbia.

The Manual is designed to assist ESRD facility staff with the provision of contracted MoKP programs and assistance. The Manual is edited and distributed through MoKP administrative office.

Requests, Suggestions and Comments may be addressed to:

Missouri Kidney Program
AP Green Building – Suite 111
201 Business Loop 70 West
Columbia, MO   65211-8180

Local:   573.882.2506
Toll Free:  800.733.7345
Facsimile:   573.882.0167

Email: PeaceLJ@health.missouri.edu
Web:  http://som.missouri.edu/mokp/

The Manual is accessible online and one hard copy is provided to each facility. We encourage you to bookmark and share this site with your staff and colleagues for future reference.

Updates to the Manual will be announced electronically via MoKP listservs.
## Table of Contents

1. **General and Administration Information**
   - 1:010 Program Statement
   - 1:020 Facility Agreement
   - 1:025 Facility Agreement and Award Worksheet – Examples
   - 1:030 Monthly Voucher Process
   - 1:040 Budget and Expenditure Report - Example
   - 1:050 Voucher by Patient Listing - Example
   - 1:060 Audit/Fiscal Reviews
   - 1:070 Payer of Last Resort

2. **Eligibility Criteria**
   - 2:010 Residence and Citizenship
   - 2:020 MO HealthNet Requirements
   - 2:030 Facility Assistance
   - 2:040 MoKP Income/Assets Eligibility Chart

3. **Application for MoKP Assistance**
   - 3:010 Application Process Overview
   - 3:020 Paper Application
   - 3:030 Online Application

4. **Direct Patient Assistance through Facility Reimbursement**
   - 4:010 Overview statement
   - 4:020 Health Insurance Premium Reimbursement

5. **Centralized Drug Program (CDP)**
   - 5:010 CDP Overview
   - 5:020 CDP Eligibility Process
   - 5:030 CDP Formulary

6. **MO HealthNet Programs**
   - 6:010 Spenddown Pay-In Program & Ticket to Work Health Assurance Program

7. **Transplant Assistance Program**
   - 7:010 Transplant Assistance Overview
   - 7:020 Transplant Assistance Process
   - 7:030 Example Letters

8. **Forms**
**EFFECTIVE 07-01-2011:**
- Elimination of the nutritional supplement assistance.
- Elimination of transportation assistance.
- Elimination of Medicare premium reimbursement assistance.
- Elimination of any insurance premiums assistance to patients **not actively** using the Centralized Drug Program.
- Eliminating patient/staff education assistance.
- Reduction in transplant/living donor grants.
- Reduction in financial eligibility asset limit to $15,000.

The mission of the Missouri Kidney Program (MoKP) is to assist eligible Missouri residents who have Stage 5 Chronic Kidney Disease or a Kidney Transplant to meet their medical and educational needs. MoKP accepts applications from end-stage renal disease (ESRD) contract facilities for direct, pre-approved patient care funds. Direct benefits of the program accrue only to Missouri residents.

The MoKP Advisory Council approves an annual facility and operating budget and a formal agreement is executed between the facility and MoKP through the University of Missouri-Columbia. The agreement, which provides for specific reimbursement in accordance with specified budget categories, is explained in the following pages.

The level of assistance may vary from facility to facility, depending on available funds.
The Agreement between MoKP, through the Curators of the University of Missouri (a public corporation), and a participating facility, authorizes MoKP to reimburse for a stated purpose, for a specific period of time (July 1 through June 30 fiscal year) for pre-approved direct cost.

The Agreement (and any amendment) must be signed by an authorized individual from each facility. This Agreement states, in part, that:

- The University may terminate this agreement or require the reduction in the extent of services contracted to match the available funds.

- University and government auditors shall have access to all records pertaining to this agreement for audit or examination. Any audit exception is the sole responsibility of the contractor and shall be refunded as necessary by contractor after all legal and administrative remedies have been exhausted.

- Progress, technical, financial and final reports will be furnished in compliance with MoKP requests, schedules and deadlines.

- The project director is responsible for assuring MoKP that annual funding requests, expenditures and changes requested during the course of the year are in the best interests of the patients.

- Missouri residents will not be denied MoKP assistance under the Agreement due to the inability to pay in advance for said assistance.

- Either party may cancel the Agreement by giving a 30-day advance written notice.

Refer to Chapter 1 General and Administration; Section 025 to review a Facility Agreement - Example.
THIS AGREEMENT is entered into as of the first day of July, 20__ between THE 
CURATORS OF THE UNIVERSITY OF MISSOURI, a public corporation of the State of 
Missouri (University) for Missouri Kidney Program (MoKP), and 
____________________________, a transplant/dialysis facility serving End-Stage Renal 
Disease (ESRD) patients of the State of Missouri (Contractor).

University, for the use of MoKP, received an appropriation by the General Assembly 
for treatment of renal disease. Reimbursement for pre-approved direct costs will be 
disbursed monthly.

The parties have entered into this Agreement for the accomplishment of the Award, 
which has been determined to be within the purpose indicated by the above-mentioned 
appropriation, and agree as follows:

1. For the consideration hereafter set forth, Contractor agrees to provide the 
necessary personnel, facilities, related resources and skills to perform and accomplish the 
Award in accordance with its Award of Funds (Appendix I).

2. Commencing July 1, 20__ and continuing through June 30, 20__, Contractor shall 
perform the work called for in the Award.

3. During the period of performance set forth above, as reimbursement for pre-
approved direct costs under the terms of this Agreement, University agrees to pay 
Contractor an amount agreed upon by the partied for pre-approved direct costs. Payments 
will be made upon receipt of approved monthly statements submitted by Contractor to
University and received by University by the end of the following month. Contractor further agrees and understands that the funds from which University shall make these payments are derived from appropriated state funds, and in the event University should not receive these funds for whatever reason, University may terminate this Agreement or require the reduction in the extent of services contracted hereunder to match the available funds.

4. Contractor agrees that any line item variation from the Award budget, which is attached hereto and incorporated by reference as Appendix I, must be approved in advance in writing by the MoKP for University.

5. Contractor agrees that, for the purpose of audit or examination, University and governmental auditors and representatives shall have access at any reasonable time to any of the books, documents, papers and records of Contractor recording receipts and disbursements of any of the funds made available to Contractor under this Agreement. Contractor further agrees that any audit exception noted by governmental auditors or University auditors or representatives shall be refunded to University as necessary by Contractor and shall be the sole responsibility of Contractor after exhaustion of all administrative and legal remedies.

6. Contractor agrees that all funds received under this Agreement will be held and used by Contractor for the purposes billed and reimbursed for, and none of the funds so held or received shall be diverted to any other use or purpose.

7. Contractor agrees to abide by and comply with the current regulations and policies outlined in the MoKP Facility Guidelines Manual and any amendments thereto which may be issued during the performance of this Agreement.

8. Contractor agrees not to deny MoKP assistance under this Agreement to Missouri residents due to their inability to pay in advance for said assistance.
9. Contractor understands and agrees that University is responsible for the administration of this Award and agrees to comply with all requests and directives which may be given by University in the implementation or accomplishment of the Award.

10. Contractor agrees to furnish financial and final reports to University through the MoKP in compliance with requests, schedules and deadlines for such reports and information.

11. Contractor agrees that this Award will be directed by
__________________________________, ________________________________________,
__________________________________, and Contractor will not substitute any other person as Project Director without securing written permission of University in advance. Contractor further agrees that its Project Director is the person to whom all official notices and requests relating to the performance of this Agreement should be addressed.

12. Contractor agrees that copies of any publications relating to the MoKP are to be furnished to University for the MoKP within a reasonable time prior to publication or distribution.

13. The parties mutually agree that any clause or provision required by law, rule or regulation to be inserted herein shall be deemed to be incorporated herein by reference as though fully set forth and shall constitute a part of this Agreement, and that this Agreement may be physically amended on the application of either party to insert any such required provision.

14. The parties mutually agree that either party may terminate this Agreement by giving thirty (30) days advance written notice of intent to terminate to the other party, or the MoKP may implement reduction as stated in paragraph 3 above.
15. The parties mutually agree that this Agreement shall be binding upon and inure to the benefits of the parties hereto and their successors and assigns, but neither party may assign this Agreement without advance Written consent of the other.

16. Contractor attests that it has the proper authority to do business in the State of Missouri.

17. This Agreement shall be governed by the laws of the State of Missouri. The parties have caused this Agreement to be executed by their duly authorized representatives as of the first day of July, 20__.

18. The University serves from time to time as a contractor for the United States government. Accordingly, the provider of goods and/or services (contractor) shall comply with federal laws, rules and regulations applicable to subcontractors of government contracts including those relating to equal employment opportunity and affirmative action in the employment of minorities (Executive Order 11246), women (Executive Order 11375), persons with disabilities (29 USC 706) and Executive Order 11758, and certain veterans (38 USC 4212 -formerly [2012]) contracting with business concerns with small disadvantaged business concerns (Publication L. 95-507). Contract clauses required by the Government in such circumstances are incorporated herein by reference.
THE MISSOURI KIDNEY PROGRAM

By ____________________________
Leanne J. Peace
Director

THE CURATORS OF THE UNIVERSITY OF MISSOURI UNIVERSITY

By ____________________________
Jennifer Duncan
Sponsored Program Administration

Facility Name and Address
______________________________

Corporate Affiliation (if applicable)
______________________________

______________________________

______________________________

By this signature I also attest that I am a duly appointed representative of the Contractor and have the authority to execute this Agreement on behalf of the Contractor.

By ____________________________

Type: ____________________________

Name ____________________________

Title ____________________________

CONTRACTOR

By ____________________________

Type: ____________________________

Name ____________________________

Title ____________________________

WITNESS
Reimbursement for pre-approved direct costs will be disbursed monthly. Contractor agrees to provide the necessary personnel, facilities, related resources and skills to perform and accomplish the work as follows:

ASSISTANCE

Transportation Assistance
Transportation assistance is not being offered at this time, however funding may be available in the future to pre-approved patients. Transportation funds are allocated to help cover expenses for patient travel to and from a dialysis or transplant facility. Patient eligibility requirements are outlined in the MOKP Facility Guidelines Manual.

Premiums
Financial assistance for Premium payments are allowed for a patient's Medicare Supplemental insurance and major medical policies. Patient eligibility requirements are outlined in the MOKP Facility Guidelines Manual. Medicare Part B Premium assistance is not being offered at this time, however funding may be available in the future to pre-approved patients.

Emergency Immunosuppressive Drug Co-Pays
Emergency immunosuppressive drug funds are available for pre-approved patients. Patient eligibility requirements are outlined in the MOKP Facility Guidelines Manual.
Facilities are reimbursed on a monthly basis for expenditures incurred by MoKP patients. This process generally occurs the third Thursday of each month. The process is initiated by closing the facility access to the online billing system. Expenditures that were requested thru the online billing system will be processed and a check generated the following Tuesday.

The Budget and Expenditure Report along with the Voucher by Patient Listing is available through MoKP Ebase to the Single Point of Contact (SPOC). Logon to Ebase, chose the report you would like to view and/or print.

The top portion of the Budget and Expenditure Report provides the facility with a running total of reimbursement request by payment date and service month for the current fiscal year.

The bottom portion of the Budget and Expenditure Report shows the Current Month Activity and also shows the Year-to-Date information. It allows MoKP and the facility to plan for the remainder of the fiscal year.

The Voucher by Patient Listing provides the facility with a list of specific patients for which reimbursement was requested.
### Missouri Kidney Program
#### Budget & Expenditure Report
June 2011

**Facility Name:** Test Facility

**Facility #500**

<table>
<thead>
<tr>
<th>Payment Date</th>
<th>Service Month</th>
<th>Section 1</th>
<th>Immunos</th>
<th>Drug</th>
<th>Education</th>
<th>Private Premium</th>
<th>Medicare Premium</th>
<th>Nutritional Supplement</th>
<th>Transplant Assistance</th>
<th>Transportation</th>
<th>Section 2 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/23/2011</td>
<td>07-2011</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$375.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$375.00</td>
</tr>
<tr>
<td>09/27/2011</td>
<td>08-2011</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$375.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$375.00</td>
</tr>
<tr>
<td>10/25/2011</td>
<td>09-2011</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$375.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$375.00</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$1125.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$1125.00</strong></td>
</tr>
</tbody>
</table>

#### Current Month Activity

<table>
<thead>
<tr>
<th></th>
<th>Pt Services</th>
<th>Educ</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Adjustments</td>
<td>$375.00</td>
<td>$0.00</td>
<td>$375.00</td>
</tr>
<tr>
<td>Expenditures</td>
<td>$375.00</td>
<td>$0.00</td>
<td>$375.00</td>
</tr>
</tbody>
</table>

#### Year-To-Date Activity

**July 1 to Current**

<table>
<thead>
<tr>
<th></th>
<th>Pt Services</th>
<th>Educ</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Adjustments</td>
<td>$1125.00</td>
<td>$0.00</td>
<td>$1125.00</td>
</tr>
<tr>
<td>Actual Expenditures</td>
<td>$1125.00</td>
<td>$0.00</td>
<td>$1125.00</td>
</tr>
</tbody>
</table>

**YTD Actual Balance**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Report Date: 06/01/2011

Page: 1

SPOC: FNAME LNAME
Vendor #:0100005000-001
Deptid: C123456
MoCode: CT600
Facility Name: Test Facility

Missouri Kidney Program
Voucher by Patient Listing

<table>
<thead>
<tr>
<th>Name</th>
<th>Section I 5601</th>
<th>Transp 5603</th>
<th>Drug 5602</th>
<th>Private Prem 5609</th>
<th>Medicare Prem 5604</th>
<th>Supp 5607</th>
<th>Transp Assist 5605</th>
<th>Immuno 5610</th>
<th>Educ 5606</th>
<th>Total</th>
<th>Service Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/11 LNAME, FNAME</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$150.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$150.00</td>
<td>09/2011</td>
</tr>
<tr>
<td>LNAME, FNAME</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$125.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$125.00</td>
<td>09/2011</td>
</tr>
<tr>
<td>LNAME, FNAME</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$100.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$100.00</td>
<td>09/2011</td>
</tr>
</tbody>
</table>

**Monthly subtotal:**

$0.00 | $0.00 | $0.00 | $325.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $325.00

**Education:**

$0.00

**Voucher Total:**

$325.00

Report Date: 06/01/2011  8:38AM    E:Mokp-Web/reports/vchr_pat_list.rpt    Page 1
Random facility audits are performed to ensure reimbursements are compliant. A facility’s failure to furnish, reveal and retain adequate documentation for services billed to MoKP may result in the recovery of the payments for those services not adequately documented and may result in termination in the participation in MoKP. This continues to be applicable in the event the facility discontinues as an active participant with MoKP, change of ownership or any other circumstance.

The facility may randomly be contacted during the contract period to ensure that expenditures and records are in accordance with the contract guidelines.

For any refunds due MoKP as a result of an audit, the facility will have the opportunity to accept the findings or submit documentation showing why a refund should not be assessed.

All records are to be retained at the facility for five years.

University and government auditors shall have access to all records pertaining to MoKP billings. All MoKP billings and/or reimbursements are subject to audit by University of Missouri-Columbia and government auditors.
Use of funds through MoKP contracts commits the facility to exert all possible efforts to enroll each ESRD patient in the Medicare, MO HealthNet, Medicare supplement programs (Medigap) and/or private/group insurance (possibly through the spouse’s employer) and to collect from all other sources prior to using MoKP funds to cover any unpaid Medicare allowable amounts.

MoKP assumes no responsibility for full reimbursement of charges not collected from other sources. MoKP is not responsible for charges disallowed by a third party due to administrative oversight, such as billing incorrectly and/or on an untimely basis.

In the event a primary or secondary payer makes a payment directly to a patient rather than the facility, it is the responsibility of the facility to collect payment from the patient.

Reference Chapter 4 Direct Patient Assistance through Facility Reimbursement; Section 030 Health Insurance Premium Reimbursement.
EFFECTIVE 07-01-2011:

- Elimination of the nutritional supplement assistance.
- Elimination of transportation assistance.
- Elimination of Medicare premium reimbursement assistance.
- Elimination of any insurance premiums assistance to patients not actively using the Centralized Drug Program.
- Eliminating patient/staff education assistance.
- Reduction in transplant/living donor grants.
- Reduction in financial eligibility asset limit to $15,000.

To qualify for MoKP assistance, individuals must meet certain residence and citizenship requirements.

CITIZENSHIP:
To qualify for assistance, an individual must be:

- A resident of the State of Missouri and
- United States citizen; or
- Alien in lawful temporary resident (LTR) status; or
- Alien lawfully admitted for permanent residence or permanently residing in the US under color of law.

RESIDENCE:
The definition of a resident includes anyone who, at the time of application for MoKP assistance, is residing in the State, is not receiving assistance from another state, and entered the State with the intention of remaining in the State. The applicant must have entered the State voluntarily with the intention of making his/her home here either permanently or indefinitely and not for a temporary purpose.

For the purpose of determining eligibility for MoKP assistance, ‘residence’ means the place where a person is currently residing, provided they live there voluntarily and intend to remain. An intention to return to a former out-of-state residence at some indefinite future time does not mean the person has not established residency where they currently reside.

Alien status patients must apply for MO HealthNet before determination is made as to MoKP eligibility. Alien patients must also verify that their consulates will/will not pay medical expenses while residing in the United States.
The above policy is excerpted from the Missouri Department of Social Services – Family Support Division – Income Maintenance Manual – Dec 73 Requirements – Section 1015.000.00 and will serve as a guideline regarding questions related to eligibility for MoKP assistance. You may review the requirements in their entirety at http://www.dss.mo.gov/fsd/iman/dec1973/ertoc.html.

MO HealthNet’s Income Maintenance Manual – Dec 73 Requirements in its entirety will serve as the final authority regarding questions of eligibility related to citizenship and/or residence. You may review the manual in its entirety at: http://www.dss.mo.gov/fsd/iman/index.html.
In addition to maintaining Medicare eligibility, dialysis and transplant patients must apply for MO HealthNet benefits immediately UNLESS the following conditions exist:

- The patient has income and resources/assets (checking/savings accounts, CDs, IRAs, Money Market accounts, Stocks/Bonds, etc) exceeding MO HealthNet guidelines.
- The patient owns property in addition to their primary residence, or has life insurance with cash surrender value exceeding MO HealthNet guidelines.
- The transplant patient is no longer considered disabled.

Since MO HealthNet eligibility requirements are more stringent than MoKP eligibility requirements, in order to reduce paperwork and workload for facility and MoKP personnel, MO HealthNet eligibility is accepted as a proxy for proof of MoKP eligibility. For applicants not eligible for MO HealthNet benefits, eligibility will be based on the patient’s income and assets. The following applicants must disclose income and assets:

1. MO HealthNet Blind Pension cases do not have a proxy.
2. MO HealthNet for Kids and/or Families cases does not have a proxy.
3. MO HealthNet spenddown cases over $1,200 will require review of income and assets and possibly an exception to income application.

Alien status patients must apply for MO HealthNet before determination is made as to MoKP eligibility. Alien patients must also verify that their consulates will/will not pay medical expenses while residing in the United States.

Applications for MO HealthNet for Aged, Blind & Disabled (MHABD) should be sent to the Family Support Division (FSD) Eligibility Specialist located at the MoKP administrative office in lieu of having the applicant apply at their local FSD county office. This will expedite the processing of the MHABD application. You can obtain MHABD applications from your MoKP Coordinator or from the website at: [http://www.dss.mo.gov/fsd/pdf/im1ma_0706.pdf](http://www.dss.mo.gov/fsd/pdf/im1ma_0706.pdf).

For new ESRD patients, if disability has not been established by the Social Security Administration, attaching a copy of the completed CMS Form 2728 to a MHABD application will expedite establishment of disability which expedites approval of the MHABD application.

MoKP will make the final determination as to whether or not a patient will be required to apply for MO HealthNet benefits because of financial status or physical dysfunction.
Patients with ANY form of MO HealthNet benefits are required to keep their coverage current to receive MoKP assistance. This includes Qualified Medical Benefits (QMB) and/or Specified Low-income Medicare Benefits (SLMB) coverage for payment of Medicare Part B premiums, when applicable. For patients with continuous MHABD, QMB/SLMB coverage is required unless this benefit would put the applicant into a spenddown status.

MoKP may pay spenddown for eligible patients when funds are available. Facility social workers will receive notification listing of spenddown patients for whom MoKP has not paid in the spenddown for that given month. In those cases, the dialysis/transplant facilities are required to send medical charges incurred by their facility to the FSD Eligibility Specialist located at the MoKP administrative office as soon as the incurred charges meet the patient’s spenddown.

MoKP/State FSD Eligibility Specialist, Tricia Lutz – Fax 573-884-5276

When a patient’s MO HealthNet case is closed (terminated), it may be necessary to terminate their MoKP benefits as well. MoKP will send a termination letter stating reapplication for MHABD must be made within 30 days or their MoKP benefits will be terminated at the end of the 30 days. During this 30-day period, the patient has the opportunity to request a hearing before the MoKP Director or designee to justify why MoKP should not terminate benefits. Or, if their MO HealthNet case is closed (terminated) due to resources, the patient will be required to submit income and asset verification to the MoKP.

NOTE: The applicable social worker will receive copies of all correspondence sent to the patient.
EFFECTIVE 07-01-2011:
- Elimination of the nutritional supplement assistance.
- Elimination of transportation assistance.
- Elimination of Medicare premium reimbursement assistance.
- Elimination of any insurance premiums assistance to patients not actively using the Centralized Drug Program.
- Eliminating patient/staff education assistance.
- Reduction in transplant/living donor grants.
- Reduction in financial eligibility asset limit to $15,000.

Facility assistance should be used to defray out-of-pocket expenses incurred by MoKP patients. Facilities may reimburse the patient directly or reimburse the patient’s provider on behalf of the patient. Either method requires the facility to have proof of payment to the provider or patient prior to requesting reimbursement from MoKP.

- All patients must meet the citizenship and residency eligibility requirements referenced in Chapter: 2 Eligibility Criteria; Section 020 MO HealthNet Requirements.
- All patients must have made application to Medicare.
- All patients must have made application to MO HealthNet, if applicable. If the patient is denied coverage or does not qualify for MO HealthNet they must meet the following MoKP income/asset eligibility requirements:

ASSET GUIDELINE:
Asset Limit is $15,000 regardless of the number of dependents. Assets are defined as liquid assets; savings, investments or real estate. They DO NOT include the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.

SPENDDOWN (Limit):
Spenddown maximum = $1,200/month.

GENERAL ELIGIBILITY:
All patients must meet the following criteria on an ongoing basis in order to receive Facility Assistance:
- Stage 5 Chronic Kidney Disease diagnosis or received a Kidney Transplant.
- One of the following:
  1. Current MO HealthNet approval,
MoKP Facility Guidelines Manual
University of Missouri-Columbia

Chapter 2
Eligibility Criteria

Section 030
Facility Assistance

If conditions that affect eligibility should change, the patient and/or the social worker must notify MoKP immediately.

MEDICAL ELIGIBILITY:
In addition to the foregoing, one of two ‘critical events’ must have occurred:
1. First chronic renal dialysis treatment has occurred,
2. Hospitalization occurring within 30 days prior to initiating dialysis or receiving a transplant for renal-related diagnosis has occurred.

Note: The completion of CMS Form 2728 on a given patient must occur before any expenses can be reimbursed. CMS Form 2728 does not need to be submitted to MoKP. However, if a copy of the completed form is submitted with the Application for MO HealthNet for Aged, Blind, & Disabled (MHABD) to FSD, establishment of disability and approval of MHABD will be expedited.

ASSISTANCE PERIODS:
MoKP applicants are generally approved for an initial one-year period. Annual reviews are conducted and approvals are extended in one-year increments providing MO HealthNet coverage is maintained appropriately and/or there are no significant income/asset changes. An “approval letter” is sent to the patient and social worker that contain the dates of the patient’s assistance period.

The initial assistance period begins the day the application for assistance is approved. An approval period is given in the letter. Non-use of assistance may shorten the original one year approval period.

PRIVATE/GROUP MEDICAL INSURANCE PREMIUMS:
Private/Group medical insurance premium assistance will be retroactive to the first day of the month that the completed application was received.

For example:
- If the completed application was received on Jan 25 but not approved until Feb 11, private/group medical insurance premium assistance will begin on Jan 1.
- If the application is received incomplete Jan 25 and the MoKP Coordinator requests additional information that is not received until Feb 3, the approval date may still be Feb 11 but the private/group medical insurance premium assistance will begin Feb 1.

Since most insurance companies require premiums to be paid a month in advance of coverage, the coverage month of the premium is more than likely the month following reimbursement. Premium reimbursement made in December would be for January coverage.

Revised June 2011
Page 2 of 3
MEDICARE ADVANTAGE PLANS:
MoKP prefers not to provide assistance for patients choosing to enroll/maintain enrollment in Medicare Advantage (MA) or Medicare Advantage Prescription Drug (MAPD) plans.

MA/MAPD plans increase the financial liability MoKP may experience compared to original Medicare with or without a Medicare Supplement Plan and/or Mo HealthNet for the following reasons:

- The financial liability affects the patient, medical facility and MoKP not only in the cost of medications and immunosuppressants, but also in a limited formulary.

- These plans do not allow a patient’s incurred medical charges to meet their MHN spenddown. In turn this creates lack of access to MHN transportation and/or federal match dollars for transportation expenses funded through MoKP.

- MA/MAPD plans also limit access for the patient to specific providers and pharmacies.

If a patient becomes enrolled in a MA/MAPD plan the MoKP Coordinators will investigate the situation. Then consult with the facility social workers to provide guidance for the patient regarding the best third party payor coverage for both the patient and MoKP’s benefit.

If other reasonable options are available and the patient chooses to stay with the MA/MAPD plan, MoKP reserves the right to terminate and/or deny the application for assistance.

EMERGENCY IMMUNOSUPPRESSIVE CO-PAYS:
Co-pay assistance will begin when the application is approved.

The medications must be covered by the MoKP Drug Formulary.

As of January 1, 2006 Medicare beneficiaries enrolled in either Medicare Part A or Part B are eligible for Medicare Part D – prescription drug coverage. Patients on the Centralized Drug Program (CDP) can use their Part D prescription card at a local pharmacy in order to begin drug therapy immediately. If the prescription is a maintenance prescription and the patient is on the CDP it should be transferred after the first fill. Only controlled substances (the ones that the contract pharmacy cannot send through the mail) or short-term drug therapies should be obtained from a local pharmacy if the patient is eligible for CDP.

In the situations in which the patient must use a specialty pharmacy (could be the type of medication, Immunosuppressive, or it could be a requirement of insurance) therefore unable to be on the CDP.

NOTE: Routine co-pays will not be reimbursed by the facility if the patient chooses to use a local pharmacy instead of the CDP contracted pharmacy or is required to use a mail-order pharmacy.
For applicants not eligible for MO HealthNet, eligibility will be based on the patient’s income and assets.

### Routine Medications (150% of FPL)

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Annual</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$18,090</td>
<td>$1,508</td>
</tr>
<tr>
<td>2</td>
<td>$24,360</td>
<td>$2,030</td>
</tr>
<tr>
<td>3</td>
<td>$30,630</td>
<td>$2,553</td>
</tr>
<tr>
<td>4</td>
<td>$36,900</td>
<td>$3,075</td>
</tr>
<tr>
<td>5</td>
<td>$43,170</td>
<td>$3,598</td>
</tr>
<tr>
<td>For each add’l dependent add</td>
<td>$6,270</td>
<td>$523</td>
</tr>
</tbody>
</table>

### Private Insurance Premiums (175%FPL)

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Annual</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$21,105</td>
<td>$1,759</td>
</tr>
<tr>
<td>2</td>
<td>$28,420</td>
<td>$2,368</td>
</tr>
<tr>
<td>3</td>
<td>$35,735</td>
<td>$2,978</td>
</tr>
<tr>
<td>4</td>
<td>$43,050</td>
<td>$3,588</td>
</tr>
<tr>
<td>5</td>
<td>$50,365</td>
<td>$4,197</td>
</tr>
<tr>
<td>For each add’l dependent add</td>
<td>$7,315</td>
<td>$610</td>
</tr>
</tbody>
</table>

### Immunosuppressant Medications (250%FPL)

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Annual</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$30,150</td>
<td>$2,513</td>
</tr>
<tr>
<td>2</td>
<td>$40,600</td>
<td>$3,383</td>
</tr>
<tr>
<td>3</td>
<td>$51,050</td>
<td>$4,254</td>
</tr>
<tr>
<td>4</td>
<td>$61,500</td>
<td>$5,125</td>
</tr>
<tr>
<td>5</td>
<td>$71,950</td>
<td>$5,996</td>
</tr>
<tr>
<td>For each add’l dependent add</td>
<td>$10,450</td>
<td>$871</td>
</tr>
</tbody>
</table>

**ASSETS GUIDELINES:**
Asset Limit is $15,000 regardless of the number of dependents.

**SPENDDOWN MAXIMUM:**
Maximum spenddown = $1,200
EFFECTIVE 07-01-2011:
- Elimination of the nutritional supplement assistance.
- Elimination of transportation assistance.
- Elimination of Medicare premium reimbursement assistance.
- Elimination of any insurance premiums assistance to patients not actively using the Centralized Drug Program.
- Eliminating patient/staff education assistance.
- Reduction in transplant/living donor grants.
- Reduction in financial eligibility asset limit to $15,000.

Persons wishing to be considered for assistance from the MoKP must complete an application for MoKP Assistance and provide requested supporting documentation. The social worker and patient will complete the application and mail it to the MoKP. **Faxed applications are not accepted.** Social worker and patient signatures must be original.

The application contains the following:
- Demographic information
- Medicare, Mo HealthNet and other insurance information
- Diagnosis information
- Type of assistance requested, including a justification for funding which must be signed by the social worker
- Income/Asset information which must be submitted if the potential patient is not eligible for one of the following 3 categories:
  - MO HealthNet for the Aged, Blind and Disabled (MHABD) Continuous
  - MHABD spenddown under $1,200
  - Ticket to Work Health Assurance (TWHA) Program
- Patient Release form which must be signed by the patient

Applications may be obtained by the social worker at a MoKP contract facility by contacting the MoKP office:

Missouri Kidney Program
AP Green Building – Suite 111
201 Business Loop 70 West
Columbia, MO 65211-8180
1-800-733-7345

The social worker will forward the completed application, including required documentation to the MoKP for determination of the individual’s eligibility for assistance.
Applications will be reviewed by the MoKP Coordinators in the first 20 days of receipt. If the application is complete and/or MO HealthNet status is active and all requirements are met, the patient will receive a MoKP Award Letter. Copies of the letter will be sent to the facility social worker.

**NOTE:** Social workers will receive copies of all communications MoKP has with the patients.

Applications cannot be processed until all requested information and documentation is received. The social worker will be contacted to request any missing information or documentation. If the requested information is not received, the MO HealthNet application is not complete or is denied, etc., the application will be terminated.

Patients are awarded approval for assistance typically for one-year periods.

**MoKP PATIENT FILE MAINTANANCE INFORMATION:**
Changes in income, insurance coverage, MO HealthNet status, Medicare status or residence must be forwarded to MoKP by patient and/or social worker.

Facility staff is required to notify MoKP staff of patient transfers between facilities. It is not necessary to complete another application for those patients who transfer from one facility to another; please notify MoKP immediately, either in writing or by telephone.

**MO HEALTHNET PROXY:**
MO HealthNet eligibility requirements are more stringent than MoKP eligibility requirements, therefore, in order to reduce paperwork and workload for the facility and MoKP personnel, MO HealthNet eligibility will be accepted as a proxy for proof of MoKP eligibility in the following categories:

- MHABD Continuous
- MHABD spenddown under $1,200
- Ticket to Work Health Assurance (TWHA) Program

For non-MO HealthNet eligible applicants or MO HealthNet assistance other than the 3 above categories above income/asset eligibility requirements will be followed.

**ANNUAL RENEWAL PROCESS:**
The following is for patients NOT in one of the following categories i.e. not eligible to be automatically approved for MoKP assistance another 12 months:

- MHABD Continuous
- MHABD spenddown under $1,200
- Ticket to Work Health Assurance (TWHA) Program
Annually, the patient not auto-enrolled for another year due to MO HealthNet eligibility will be mailed a Renewal Application Form along with a letter containing instructions for completion. These patients will be required to complete and return to MoKP the annual Renewal Application Form and the requested documents including but not limited to; current income, assets, and current insurance information. Facility social workers will receive copies of correspondence sent to patients regarding the update. If the patient exceeds MoKP guidelines the patient and social worker will be contacted.

Applicants with one of the 3 following categories of MO HealthNet assistance:

- MHABD Continuous
- MHABD spenddown under $1,200
- Ticket to Work Health Assurance (TWHA) Program

Patients in one of the 3 above categories do not require an Annual Renewal Application Form to be completed nor do they need to submit income and asset information. These patients receive a letter stating that they will be automatically renewed for another one-year contingent on there not being any changes in their financial situation. Income or MO HealthNet status changes may trigger a review to determine whether the patient continues to meet eligibility criteria.

**NOTE:** Approval by the MoKP Coordinator for financial assistance is always contingent on continued availability of funds to the MoKP and/or as budgeted through the renal facility.
EFFECTIVE 07-01-2011:

- Elimination of the nutritional supplement assistance.
- Elimination of transportation assistance.
- Elimination of Medicare premium reimbursement assistance.
- Elimination of any insurance premiums assistance to patients not actively using the Centralized Drug Program.
- Eliminating patient/staff education assistance.
- Reduction in transplant/living donor grants.
- Reduction in financial eligibility asset limit to $15,000.

The patient should complete the MoKP application with assistance from the facility social worker. All blanks should be completed or N/A written to indicate this information does not apply. Incomplete applications will be held until all requested information and documentation is received.

NOTE: Social worker and patient signatures must be original—not copies.

An application is included in this section for reference. Following is a description of information requested:

PAGE ONE: (this page is to be completed by the patient and/or the social worker)

**Name** = use full legal name with middle initial, no nicknames

**Sex** = check male or female

**Permanent Address** = the permanent address where the patient resides. Street/Route #, City, State and Zip Code must all be listed for the patient. If the patient receives his/her mail at a PO Box, note the mailing address in the comments to explain the reason for difference in address.

In addition to the PO Box, please also note the patient’s physical address to verify that he/she is a resident of Missouri. **Zip code accuracy is of the utmost importance when requesting assistance with medications.**

NOTE: In a few instances, a relative or Power of Attorney is responsible for processing mail for a patient. If this is the case, please note the patient’s address, and then also note the name, relationship and address of the person responsible for processing mail.

**County (if St Louis, indicate city or county)** = the county where the patient resides (not the mailing address if mailing address is not patient’s home.).

**Telephone number, including area code** = patients phone number. If the patient does not have a telephone, please note a contact person-name, relationship and phone number. **Include mobile phone numbers when possible.**
**Social Security Number** = the nine digit social security number

**Date of Birth** = Month, Day, Year

**Marital Status** = check married or single

**Number of Dependents, including yourself** = number of dependents claimed on the patient’s tax return (which does include self)

**Ethnic Origin** = circle ethnic origin

**Medicare Number** = the number, including the alpha character, from the patient’s Medicare card. *A copy of the card is very helpful.*

**Effective Date (Part B)** = the effective date of part B as shown on the card.

**If not eligible for Medicare, indicate reason** = list the reason the patient does not have and/or is not eligible for applying for Medicare.

**MO HealthNet** = the nine digit MO HealthNet case number as indicated on the MO HealthNet card. All Patients that are financially eligible for MO HealthNet must apply for and cooperate with MO HealthNet and maintain Active status.

**If not eligible for MO HealthNet indicate reason** = list the reason why the patient is not eligible for MO HealthNet. Submit a copy of the rejection letter.

**Military benefits** = is the patient or spouse, eligible for military benefits – check yes or no. If yes, please attach a copy of the patient’s TriCare or ChampVA card. If the patient is only eligible for assistance through the VA center please note as such.

**MC+ Assistance for Families benefits** = is the patient receiving MC+ or Assistance for Families – check yes or no. If the patient is receiving MC+ or Assistance for Families, income and asset documentation must be attached.

**Blind Pension benefits** = are you receiving Blind Pension– check yes or no. If the patient is receiving Blind Pension, income and asset documentation must be attached.

**Other Insurance** = list all other insurance coverage, check the type of coverage, provide the name of the policyholder, policy number, group number, phone number and effective date. *A copy (front and back) of the private insurance card(s), both medical and prescription drug cards -must be submitted with the application.*

---

**PAGE TWO:** (this page is to be completed by the social worker)

**Patient Current Status** = check dialysis or transplant; for dialysis patients list the date of the first dialysis at your facility; for transplant patients list the date of the current transplant and circle whether the transplant was a Cadaver (CAD), Living Related Donor (LRD) or Living Unrelated Donor (LUD).

**Type of Assistance Requested** = check all requested assistance.
Routine Meds - attach the Prescription Order Form (MoKP Form 103), and the Consent for Medicare Part D Enrollment (MoKP Form 117).

Immunosuppressants - attach the Prescription Order Form (MoKP Form 103), and the Consent for Medicare Part D Enrollment (MoKP Form 117)

Insurance Premiums: Private - write in the requested $ amount and attach supporting documentation.

**Justification for funding** = a detailed justification for funding is required. The justification should include financial and physical need. Incomplete or inadequate justifications may delay processing of the application.

**Date** = Month, Day, Year the social worker signed the application.

**Social Worker Signature** = Signature of social worker submitting the application. Illegible signatures may delay processing of the application.

**Facility** = Facility where this patient will be followed.

**PAGE THREE:** (this page is to be completed by the patient and/or social worker)

**NOTE:** *This page should be completed unless the patient is eligible for medical assistance through MO HealthNet coverage in one of the following categories:*

- MO HealthNet for the Aged, Blind & Disabled (MHNABD) Continuous,
- MHNABD spenddown under $1,200
- Ticket To Work Health Assurance (TWHA) Program.

**Income Eligibility** = For purposes of eligibility, MoKP considers the income of all dependents or individuals living in the household, including the applicant, who are either supported by the applicant or who are contributing to the support of the household where the applicant resides.

If the applicant files taxes, MoKP uses the income reported and the number of dependents claimed on the applicant’s tax return. If the applicant does not file taxes but is claimed as a dependent by another, MoKP uses the income and number of dependents claimed on the tax return of the person who is claiming the applicant as a dependent.

If the applicant claims no current income stream MoKP considers the income stream of the person who is providing for or residing with the applicant.

If the applicant or the person who is providing support did not previously file taxes then three consecutive pay stubs of all household members may be used to determine eligibility.

To determine eligibility, an applicant **must** provide documentation of the income stream.
**Assets** = The MoKP asset limit for purposes of eligibility is $15,000 per household. Assets generally include all liquid assets and/or real property not the primary residence.

Enter the appropriate $ amount in each blank or write $0.00 if the patient does not have the noted account. Each _____ (blank) must be completed. The most recent account statements must be attached. Documents/statements required include but are not limited to checking account, savings account, CD/IRA, Stocks/Bonds/Mutual fund balances and any other monetary asset.

Full disclosure of all household income and assets is required. If the household does not have income or assets, disclosure of income and assets of the person(s) providing the assistance for housing, food, personal care items, etc, is required.

**PAGE FOUR:** (this page is to be completed by the social worker)
The social worker is required to circle the appropriate primary cause of renal failure – diagnosis.

**PAGE FIVE:** (this page MUST be signed by the patient)
Refer to Chapter 3 Application for MoKP Assistance; Section 050 Patient Agreement – Example.
The patient must read (or have read to), sign and date this page before the application will be processed.

**PAGE SIX:** This page is for notes/comments from the applicant, the social worker, and/or MoKP Coordinator.
EFFECTIVE 07-01-2011:
- Elimination of the nutritional supplement assistance.
- Elimination of transportation assistance.
- Elimination of Medicare premium reimbursement assistance.
- Elimination of any insurance premiums assistance to patients not actively using the Centralized Drug Program.
- Eliminating patient/staff education assistance.
- Reduction in transplant/living donor grants.
- Reduction in financial eligibility asset limit to $15,000.

Online applications are electronically completed by the social worker using his/her personal social worker User ID and Password access to the data base at [https://mokp.missouri.edu/mokp_web](https://mokp.missouri.edu/mokp_web). The social worker should have all of the needed information with him/her before beginning to complete the online application. The data base is set to time out at 20 minutes. *After the 20 minutes expires, all data not submitted previously to the data base will be lost and the online application process must be initiated again.*

When the social worker enters the data base using their social worker User ID and Password the following screen is seen.

Facility Access Menu
Select the information you are interested in:
- Patient Information
- New Patient Application
- MoKP Forms
- MoKP Drug Formulary
- Facility Guidelines Manual

Select New Patient Application.

Enter patient's Social Security number: (format: xxx-xx-xxxx)

Enter the Social Security number. If you enter a Social Security number that is already in the data base, one of 2 screens will appear:

1. The Social Security number you have entered belongs to an active patient in the MoKP data base

Revised June 2011
Chapter 3
Application for MoKP Assistance

Section 030
Online Application

• If you are entering an application for a different patient, please determine the correct Social Security number for the patient, then enter the corrected number or begin the application again later.

• If this is the correct patient and Social Security number, contact your MoKP Coordinator.

This screen simply means that the Social Security number you entered is for a patient that is currently on MoKP. Call your MoKP Coordinator to make sure this patient is showing up in the data base as your patient.

2. The Social Security number you have entered belongs to a terminated patient in the MoKP data base:

• If you are entering an application for a different patient, please determine the correct Social Security number for the patient, then enter the corrected number or begin the application again later.

• If you are entering an application to re-activate a terminated patient, select the Continue function below.

The above screen copy shows that the patient applied at some time in the past for assistance but is currently not active/approved for assistance. You may choose the continue button to proceed.

Application For Missouri Kidney Program Assistance

Please Complete All Relevant Blanks - Required fields are indicated in red in the data base.

You must complete the form and exit this page within 20 minutes.

Name: First Initial Last Sex ☐ Male ☐ Female
Address1 Address2
City MO ZIP Phone (xxx-xxx-xxxx)
Social Security number 514724066 Date of Birth (mm/dd/yyyy)
Marital Status ☐ Married ☐ Single No. of Dependents (including patient)
Ethnic Origin White
Medicare # Effective Date (Part B) (mm/dd/yyyy)
Medicare Rx Start Date (mm/dd/yyyy)

Revised June 2011
MoKP Facility Guideline Manual
University of Missouri-Columbia

Chapter 3
Application for MoKP Assistance

Section 030
Online Application

-- OR -- If not eligible for Medicare, indicate reason

MO HealthNet #

-- OR -- If not eligible for MO HealthNet, indicate reason

Is the patient or their spouse eligible for military benefits? Patient ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

Is the patient receiving MC+ (AFDC) benefits? ☐ Yes ☐ No
Is the patient receiving a blind pension benefit? ☐ Yes ☐ No

Other Insurance (Leave blank if none)
Type of Coverage: (Select one)
☐ Medicare Supp./Medigap ☐ Employer Group ☐ Private/Personal ☐ Medicare Advantage
Policy No. Group No. Phone No.
Name of Policyholder Effective Date
Other Insurance Notes/Comments:

PATIENT CURRENT STATUS ☐ Dialysis ☐ Transplant
If dialysis, date of first dialysis at your facility (mm/dd/yyyy)
If transplant, date of current transplant(mm/dd/yyyy)
Type of transplant N/A or Unknown ☐ (Required if transplant patient)
Diagnosis: MoKP cannot establish eligibility without a diagnosis.

Diabetes Type II

Revised June 2011
Chapter 3
Application for MoKP Assistance

Section 030
Online Application

TYPE OF ASSISTANCE REQUESTED

☐ ROUTINE MEDICINES

Eligibility for medicines begins on the date this application is approved by MoKP.

☐ INSURANCE PREMIUMS: Private: $____ per month

☐ IMMUNOSUPPRESSANTS

Eligibility for medicines begins on the date this application is approved by MoKP.

JUSTIFICATION FOR FUNDING

(Justification should include both financial and socio-economic need)

Date: 7/21/2009

Facility: Barnes Jewish Hospital Dialysis Center

Social Worker Signature: Cynthia Murray

NOTE: An online application worksheet (MoKP Form 101) must be received within 4 business days of submitting this form. All required documentation must be included with the form before this application can be approved.

Online Application Definitions

Name = use full legal name, no nicknames

Sex = check male or female

Permanent Address = the address where the patient receives his/her mail. If the patient receives his/her mail at a PO Box, note that is the mailing address, but include in the comments the actual physical address where the patient resides. Street/Route #, City, State and Zip Code must all be listed for the patient. The patient’s physical address is needed to verify that he/she is a resident of Missouri. It is helpful to include a piece of mail that the patient has recently received at the address he/she is currently living to verify correct address. Zip Code accuracy is of the utmost importance when requesting assistance with medications.

Note: In a few instances, a relative or Power of Attorney is responsible for processing mail for a patient. If this is the case, please note the patient’s address, and then also note the name, relationship and address of the person responsible for processing mail in the justification section.

Revised June 2011
Telephone number, including area code = patient’s phone number. If the patient does not have a telephone, please note a contact person—name, relationship and phone number in the justification.

Social Security Number = this number is entered from the previous screen

Date of Birth = Month, Day, Year

Marital Status = check married or single

Number of patient’s dependents, including them self = number of dependents claimed on the patients tax return (which does include self)

Ethnic Origin = circle ethnic origin

Medicare Number = the number, including the alpha character, from the patient’s Medicare card

Effective Date (Part B) = the effective date of part B as shown on the card using mm/dd/yyyy.

If not eligible for Medicare, indicate reason = list the reason the patient does not have and/or is not eligible to apply for Medicare.

MO HealthNet = the nine digit MO HealthNet case number as indicated on the MO HealthNet card. All patients that are financially eligible for MO HealthNet must apply for and cooperate with MO HealthNet and maintain Active status.

If not eligible for MO HealthNet indicate reason = list the reason the patient has not applied for MO HealthNet or applied and was rejected. Submit a copy of the rejection letter.

Military benefits = is the patient or your spouse, eligible for military benefits – check yes or no. If yes, please submit a copy of the patient’s TriCare or ChampVA card. If the patient is only eligible for assistance through the VA center itself, please note as such.

MC+ Assistance for Families benefits = is the patient receiving MC+ or Assistance for Families – check yes or no. If the patient is receiving MC+ or Assistance for Families, income and asset documentation must be submitted.

Blind Pension benefits = are you receiving blind pension– check yes or no. If the patient is receiving Blind Pension, income and asset documentation must be submitted.

Other Insurance = list all other insurance coverage, check the type of coverage, provide the name of the policyholder, policy number, group number, phone number and effective date. A copy (front and back) of the private insurance card(s)—both medical and prescription drug cards--must be submitted with the application.

Patient Current Status = check dialysis or transplant; for dialysis patients list the date of the first dialysis at your facility; for transplant patients list the date of the current transplant and circle
whether the transplant was a Cadaver (CAD), Living Related Donor (LRD) or Living Unrelated Donor (LUD).

**Type of Assistance Requested** = check all requested assistance and when indicated state the estimated (or actual) dollar amount per month.

- **Routine Medicines**—submit the Prescription Order Form (MoKP Form 103) and the Consent for Medicare Part D Enrollment (MoKP Form 117).
- **Immunosuppressant**—submit the Prescription Order Form (MoKP Form 103) and the Consent for Medicare Part D Enrollment (MoKP Form 117)
- **Insurance Premiums: Private**—write in the requested $ amount and submit supporting documentation.

**Justification for funding** = a detailed justification for funding is required. The justification should include both financial and socio-economic need. Incomplete or inadequate justifications may delay processing of the application.

**Date** = this is completed automatically by the computer with the current date.

**Social Worker Signature** = Social worker that is signed on to the data base using User ID and Password is automatically filled in.

**Facility** = Select from the drop down menu the facility where this patient will be followed.

After submitting the online application, the following screen is displayed. Print out this screen so you know what documents you need to submit.

**Required Documentation:**

In order to have this patient considered for the MoKP program, you will need to **mail the supporting documentation listed below within four business days.** You can view and print these forms in Adobe Acrobat (PDF) format by selecting the buttons on this page. You will need the free Adobe Acrobat Reader installed on your PC in order to view or print a form. If you do not have Reader installed on your PC it can be downloaded and installed from Adobe's Web site; [click here](#) to go to the download site.

Provide a copies of the patient's **Medicare, MO HealthNet and/or private insurance cards** (both front and back), plus the following forms:

- ☐ Missouri Kidney Program On-Line Application Worksheet (MOKP 101), signed by the social worker.
- ☐ Patient Agreement Form (MOKP 107a), signed by the patient.
Income and Assets Information Form (MOKP 107) with supporting documentation as applicable.

If requesting medications assistance:
- Prescription Order Form (MOKP 103).
- Kilgore's Pharmacy Distribution Form.
- Consent for Medicare Part D PDP Enrollment (MOKP 117).

To view and/or print a form, select the form you are interested in and click on the Display Form button below. When the form has been displayed, you can print it using the Acrobat Reader Print button. Then return to this menu using your browser's Back button.

All documents as above must be submitted by mail with original signatures of the patient and social worker before the MoKP Coordinator can begin to process the online application.
EFFECTIVE 07-01-2011:
• Elimination of the nutritional supplement assistance.
• Elimination of transportation assistance.
• Elimination of Medicare premium reimbursement assistance.
• Elimination of any insurance premiums assistance to patients not actively using the Centralized Drug Program.
• Eliminating patient/staff education assistance.
• Reduction in transplant/living donor grants.
• Reduction in financial eligibility asset limit to $15,000.

Through the contracted partnership of MoKP and each facility, MoKP is able to provide direct assistance to needy Stage 5 Chronic Kidney Disease (CKD) patients.

The goal is to minimize the financial hardship that these patients face due to their chronic disease and to promote improved health. MoKP and the facilities closely work together to provide these important resources.

The following categories of assistance are provided to MoKP eligible population: insurance premium reimbursement and emergency immunosuppressive drug medication co-pays.

The following pages explain each category and process.
Financial reimbursement for round-trip travel to the closest dialysis clinic or transplant facility is available to patients who meet MoKP eligibility criteria. There is a monthly cap of $450. The least expensive form of transportation appropriate for the patient should be used, including but not limited to:

1. Mileage: Patient, family, friends, or community member drive patient to and from treatment—use Map Quest to determine the number of miles.
3. Vendor transportation.

Continuous Mo HealthNet patients are not eligible for this assistance.

**DIALYSIS PATIENTS:**
Transportation assistance is available for the round trip expense from the patient’s home to the dialysis clinic. For hemodialysis patients this would be the round trip to the dialysis unit generally 3 days a week. For home and peritoneal dialysis, the transportation assistance would be for the 2-3 week training period and then up to 2 days a month for clinic visits and/or lab work. Other doctor office visits, transportation to and from the hospital, etc, are not generally covered.

**TRANSPLANT PATIENTS:**
Transportation assistance is available for transportation to and from the transplant clinic, and to and from medical providers for follow-up lab and radiology appointments directly related to the kidney transplant.

**PROCESS:**
A MoKP Application for Assistance must be submitted to request transportation assistance, along with a Transportation Worksheet (MoKP Form 115) if the cost of the monthly transportation is less than the $450.00 cap. If the social worker is reimbursing a patient for mileage, the Patient Mileage Request Form (MoKP Form 116) will need to be completed each month. The facility must keep these forms on file for auditing purposes. If transportation expenses exceed the $450.00 cap a MoKP Transportation Exception (MoKP Form 102) must be completed and submitted in addition to the MoKP Transportation Worksheet (MoKP Form 115).
NOTE: Transportation assistance begins the first day of the month in which the application is approved or the first day of the month in which the request to add transportation assistance is received.

When completing the Transportation Worksheet (MoKP Form 115) indicate the mode of transportation needed. If Mileage reimbursement is requested, list the total # of miles for the round trip to and from dialysis. If Vendor Transportation is requested, two vendor quotes are required.

If the patient requires more than 14 dialysis trips per month, please note in the comment section the number of treatments the patient will have per month.

A new Transportation Worksheet (MoKP Form 115) must be completed when there is a change in mode, cost, patient address or facility.
MoKP is establishing an emergency Transportation Grant to assist patients as they struggle to attend their dialysis appointments. This grant is only a temporary, limited support; so long term solutions will need to continue to be explored.

Due to MoKP’s limited budget, there is only a set amount of funds allocated for this grant. **We will only approve grants up to $500 per request per patient.** It is uncertain whether these funds will last through June 2013, or continue afterwards.

**Rules:**

1. Patient must be on MoKP.
2. Patient must be on in-center hemodialysis.
3. Patient must have extreme transportation needs.
4. There is 1 request per patient up to $500. MoKP determines method of payment; either pay-in Spend Down up to $500 for 1 month, OR approve transportation (vendor/mileage) reimbursement to facility for up to $500. (*MoKP is NOT allowed to pay in partial Spend Down amounts*). Current mileage reimbursement is .23/mile.
5. This is for future transportation costs, and NOT for prior bills.
6. Social Worker to complete attached Form #102a and fax to your MoKP Coordinator.
7. Your MoKP Coordinator will respond in 3 business days, with return faxed approval form.
8. If MoKP elects to reimburse facility for transportation (mileage, vendor, or public) all bills must be submitted on-line within 90 days through the MoKP database. All expenses must be paid by the facility before submitting charges to MoKP.
MoKP provides medication assistance through a contracted pharmacy.

Benefits of using the Centralized Drug Program (CDP) include but are not limited to:

1. Medications currently on the MoKP formulary are dispensed at no cost to the patient. Medication not on the MoKP formulary is billed to the patient by the contract pharmacy.
2. Medications are mailed to the facility or by prior approval to the patient’s home (as per the instructions on the Prescription Order Form (MoKP Form 103).
3. MoKP staff will work with the contract pharmacy to manage enrollment in Medicare Part D Prescription Drug Plans (PDP) to ensure the least out-of-pocket expense.

To request Routine Medication and/or Immunosuppressant assistance for a patient the facility social worker must submit a completed Application for MoKP Assistance.

The Prescription Order Form (MoKP Form 103) must accompany the application when medicines or immunosuppressant assistance is requested. The form can be accessed from the forms menu of the Facility Access Menu. **Be sure to include any known allergies, address where medicines are to be mailed, and signed by appropriate medical personnel (i.e. physician, nurse practitioner, RN taking verbal order, etc.)**

If the patient is eligible or will be eligible in the future for Medicare, a Consent for Medicare Part D PDP Enrollment (MoKP Form 117) must be completed and signed before the MoKP Coordinator can approve the patient for the CDP.

After the MoKP Coordinator reviews the application and determines that the patient is eligible for assistance, an award letter is sent to the patient instructing them to call the contract pharmacy (the name and toll free phone number is provided) when they need their next refill.

The contract pharmacy does not mail medications until the patient or their representative calls the contract pharmacy to order refills. This prevents duplicate filling of meds, etc. Medication will be shipped through the least expensive method and facility mailings are strongly encouraged. The contract pharmacy decides the most efficient and cost effective method of shipping.

Following MoKP approval for assistance through CDP, the facility may communicate directly with the contract pharmacy to add or change prescriptions.

MoKP recommends the medications to be mailed to the dialysis facility for dialysis patients. This decreases shipping costs -- especially if several patients’ medications can be shipped together. Dialysis facilities can also use this as an opportunity to review the medications patients are taking and assess compliance.
MO HEALTHNET:
The MoKP contract pharmacy must be designated as the primary provider for MO HealthNet coverage. If MO HealthNet locks a patient into another pharmacy (ie. MO HealthNet HMO plans and/or MC+), the MoKP contract pharmacy can no longer dispense his/her medicines. If a patient is eligible for MO HealthNet, they must maintain that eligibility at all times to continue to receive assistance through the CDP.

PRIVATE INSURANCE:
The MoKP contract pharmacy has contracts with most of the private insurance companies available to Missouri residents. However, there are a few that specify where the mediations must be dispensed. In these cases, the MoKP contract pharmacy cannot dispense medication and the patient cannot be approved for CDP. Examples include but are not limited to:

- Wal-Mart employees must purchase their medications at Wal-Mart.
- Some large hospital organizations require their insured employees and retirees to use their out-patient pharmacy,
- Several private insurance companies require a specialty or mail order pharmacy for routine medications and immunosuppressants.

If a patient is eligible to have private insurance through their employer, spouse’s employer, COBRA benefits, etc., the patient must maintain that private insurance coverage while receiving assistance from MoKP. The social worker should discuss specific situations that might be considered an exception to this rule with their individual MoKP Coordinator.

CREDITABLE COVERAGE:
In order for MoKP to avoid compromising a patient’s employee group health care coverage, MoKP requires a copy of a “Creditable Coverage” letter when the patient is approved for the CDP and each year thereafter between November and January.

Each employer who offers an employee group health plan is required to annually issue a letter to all of their employees stating whether or not their insurance is deemed “creditable”. Coverage is “creditable” if the coverage equals or exceeds the drug coverage under Medicare Part D. The letter should also state whether or not the employee’s health care insurance will change, be terminated, increase in premium cost, or have no affect if the patient would decide to enroll in a Medicare Part D and use it.

MEDICARE PART D:
The contract pharmacy bills Medicare Part D plans for medications dispensed to Medicare eligible patients. MoKP requires patients to allow MoKP staff to manage their Medicare Part D enrollments to ensure that the patient is enrolled in the plan that best meets his/her needs considering the individual drugs the patient is prescribed. MoKP Consent for Medicare Part
D (MoKP Form 117) must be completed and signed annually by all patients that are approved for the CDP and are Medicare eligible. Allowing MoKP to manage enrollment in Medicare Part D Prescription Drug Plans allows MoKP to offer assistance to more Missourians through cost savings incurred in ensuring that each patient has a PDP that covers most of their specific medications.

In preparation for open enrollment MoKP staff will mail pre-printed consent forms either to dialysis social workers or directly to transplant patients in the early fall. The patient is to review the information, make any necessary changes, sign the consent form and return to MoKP by the designated date. The consent form authorizes MoKP staff to work with the contract pharmacy to ensure each patient is enrolled in a Medicare Part D Prescription Drug Plan (PDP) which covers all medications at the lowest possible cost.

NOTE: For Medicare eligible patients a copy of the signed consent form is required in order for the patient to be eligible for the CDP.

MEDICARE ADVANTAGE PLANS:
MoKP prefers not to provide assistance for patients choosing to enroll/maintain enrollment in Medicare Advantage (MA) or Medicare Advantage Prescription Drug (MAPD) plans.

MA/MAPD plans increase the financial liability MoKP may experience compared to original Medicare with or without a Medicare Supplement Plan and/or MHN (Medicaid) for the following reasons:
- The financial liability affects the patient, medical facility and MoKP not only in the cost of medications and immunosuppressants, but also in a limited formulary.
- These plans do not allow a patient’s incurred medical charges to meet their MHN spenddown. In turn this creates lack of access to MHN transportation and/or federal match dollars for transportation expenses funded through MoKP.
- MA/MAPD plans also limit access for the patient to specific providers and pharmacies.

If a patient becomes enrolled in a MA/MAPD plan the MoKP Coordinators will investigate the situation. Then consult with the facility social workers to provide guidance for the patient regarding the best third party payor coverage for both the patient and MoKP’s benefit.

If other reasonable options are available and the patient chooses to stay with the MA/MAPD plan, MoKP reserves the right to terminate and/or deny the application for assistance.

MEDICARE PART B:
The contract pharmacy bills Medicare Part B for immunosuppressants dispensed to Medicare Part B eligible patients. The patient must maintain Medicare Part B coverage if they are eligible while receiving assistance from MoKP.
**EFFECTIVE 07-01-2011:**

- Reduction in financial eligibility asset limit to $15,000.

In order to receive routine medicines and/or immunosuppressant coverage patients must complete the Application for Assistance.

All potential beneficiaries of the CDP must meet one of the following eligibility requirements:

1. **MO HealthNet eligibility if spenddown less than $1,200 month.**

For applicants not eligible for MO HealthNet, eligibility will be based on the patient’s income and assets.

2. **MoKP income/asset guideline for Routine Medications (150 of FPL):**

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Annual</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$16,335</td>
<td>$1,361</td>
</tr>
<tr>
<td>2</td>
<td>$22,065</td>
<td>$1,839</td>
</tr>
<tr>
<td>3</td>
<td>$27,795</td>
<td>$2,316</td>
</tr>
<tr>
<td>4</td>
<td>$33,525</td>
<td>$2,794</td>
</tr>
<tr>
<td>5</td>
<td>$39,255</td>
<td>$3,271.25</td>
</tr>
<tr>
<td>For each add’l dependent add</td>
<td>$5,730</td>
<td>$478</td>
</tr>
</tbody>
</table>

3. **MoKP income/asset guideline for Immunosuppressant Medications (250% of FPL):**

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Annual</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$27,225</td>
<td>$2,269</td>
</tr>
<tr>
<td>2</td>
<td>$36,775</td>
<td>$3,065</td>
</tr>
<tr>
<td>3</td>
<td>$46,325</td>
<td>$3,860</td>
</tr>
<tr>
<td>4</td>
<td>$55,875</td>
<td>$4,656</td>
</tr>
<tr>
<td>5</td>
<td>$65,425</td>
<td>$5,452</td>
</tr>
<tr>
<td>For each add’l dependent add</td>
<td>$9,550</td>
<td>$796</td>
</tr>
</tbody>
</table>

**ASSETS GUIDELINES:**

Asset Limit is $15,000 regardless of the number of dependents.
The Centralized Drug Program (CDP) formulary was developed by a group of physician advisors and approved by MoKP Advisory Board. The formulary is reviewed and revised as needed with assistance from advisory physicians and approved by MoKP Advisory Board.

Requests for changes to the formulary must be in writing and submitted to the Director of MoKP.

The current formulary can be accessed on MoKP public website at URL http://som.missouri.edu/mokp/. Click on the "Patient Assistance” tab in the menu. Click on the “View Formulary” button at the bottom of the page.

You may sort the formulary in one of two ways:
- Category
- Drug Name

Injectables -- except for Insulin -- are not covered by MoKP.
MoKP Facility Guidelines Manual  
University of Missouri-Columbia

<table>
<thead>
<tr>
<th>Chapter 6</th>
<th>Section 010</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO HealthNet Programs</td>
<td>Spenddown Pay-In Program &amp; Ticket to Work Health Assurance Program (TWHA)</td>
</tr>
</tbody>
</table>

**MO HealthNet Programs:**  
Spenddown Pay-In Program & Ticket to Work Health Assurance Program (TWHA)

MoKP recognizes the medical and financial benefit for patients having monthly “first day-first dollar” MO HealthNet insurance coverage. In addition, there is an indirect financial benefit for continuous insurance coverage for our facilities, physicians, and MoKP. To determine eligibility, MoKP staff conducts a cost-benefit analysis by comparing the patient’s premium costs to the expected medications expenses. This is a case-by-case review, and can be a month-to-month determination.

**NOTE:**  *This is NOT a direct assistance category that can be requested by the patients or the facility social workers on the application. However, the patient must be actively using the Centralized Drug Program to be eligible for this benefit. The number of patients and the dollar amount of the spenddown that are paid are strictly at the discretion of the MoKP’s staff and budget.*

Once MoKP has made the decision to pay a MO HealthNet spenddown or TWHA premium, the payment process is completed one month in advance. MoKP sends a letter to the patient and the facility social worker each month notifying them that the payment is made, and there should be no interruption of their MO HealthNet coverage.
EFFECTIVE 02-24-2012:

- Transplant grants increased to $1,000.
- A grant can be awarded for transplant expenses occurred up to 6 months after surgery.
- Insurance premium expenses previously covered by another organization. Example: Insurance premiums previously paid by American Kidney Foundation.

Transplant recipients or donors may be eligible for financial assistance to help defray out-of-pocket living expenses associated with transplantation. These recipients/donors do not have to be enrolled for MoKP assistance. A donor does not have to be a Missouri resident, but the kidney transplant recipient must be a Missouri resident.

To be considered for this type of assistance, the transplant facility social worker (or other transplant facility staff member) must submit a written request to the MoKP Director outlining the unusual financial circumstances involved.

If possible, requests should be submitted prior to the transplant surgery. MoKP will not reimburse the facility until the transplant has occurred.

The facility staff member making the request will be notified in writing of the outcome of the request.

Additionally:

- All requests will be considered on a case-by-case basis.
- Although income eligibility guidelines do not apply to transplant assistance, financial means may be considered when evaluating request.
- Transplant recipients or living donors, but not both parties, will be considered for an award. Partial awards may be requested for both recipients and donors.
- Dental and/or other medical expenses directly or indirectly related to the transplant are not covered.
- A grant can be awarded for transplant expenses occurred up to 6 months after surgery.
- Insurance premium expenses previously covered by another organization. Example: Insurance premiums previously paid by American Kidney Foundation.
EFFECTIVE 02-24-2012:
• Transplant grants increased to $1,000.

A written request, addressed to the Director of MoKP, from a transplant facility social worker or facility staff member for Transplant Assistance not to exceed $1,000 should include the following:

• Name and address of kidney recipient and/or name and address of kidney donor
• Who will receive the transplant assistance funds
• The amount requested, not to exceed $1,000 total
• Date of the transplant
• Why the recipient/s is/are in need of the assistance. Be specific, including demographic information and in general the situation, ie, why there is a need.

Following this section are two example letters for the use of the requester.

The transplant facility social worker or staff member making the request will be notified in writing of the outcome of the request.

FACILITY REIMBURSEMENT:
The facility must submit documentation to their MoKP Coordinator indicating the check amount the facility issued to the recipient and/or donor. When the MoKP Coordinator receives this documentation MoKP will reimburse the facility the amount granted including a budget adjustment with the next voucher process.

All requests for reimbursement from MoKP are subject to audit. Refer to Chapter 1 General and Administration Information; Section 1010 Audit/Fiscal Review.
May 20, 2011

Leanne Peace, Director  
Missouri Kidney Program  
AP Green Building  
201 Business Loop 70W Room 111  
Columbia, MO  65211-8180  
Re:  Transplant Donor Assistance

Dear Mrs. Peace:

I am writing regarding donor financial assistance for XXXXXX, who plans to donate a kidney to his mother, YYYYYY, on 7/2/11.  Both donor and recipient are Missouri residents.

XXXXXX is a 19 year-old single male.  He lives with his parents and his 13 year-old sister.  He is employed part-time at Dominos pizza, working 20-23 hours per week.  He is paid $5.50 per hour.  He is also going to school full-time at Florissant Valley Community College in Accounting where he is a sophomore.  The transplant is planned for early June so XXXXXX can finish school year and recuperate s/p surgery.  He will need to be off work for approximately 6 weeks.  Unfortunately, since he is working part-time, he is not sure if they will hold his job for him after surgery.

Expenses are as follows:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>$ 40.00</td>
</tr>
<tr>
<td>Car Payment</td>
<td>$136.00</td>
</tr>
<tr>
<td>Car Insurance</td>
<td>$150.00</td>
</tr>
<tr>
<td>Gasoline</td>
<td>$ 40.00</td>
</tr>
<tr>
<td>Loan ($600 total)</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

*$466.00 TOTAL*

Please assist XXXXXX with a grant of $500.00 for living expenses while he is off work after transplant surgery.  Thank you in advance for your assistance.  If you have additional questions, please feel free to contact me at 314-362-5577.

Sincerely,

Revised June 2011
July 20, 2011

Leanne Peace, Director
Missouri Kidney Program
AP Green Building
201 Business Loop 70W Room 111
Columbia, MO  65211-8180

RE: Transplant Assistance Grant

Dear Leanne,

I am requesting a grant of $500 to assist XXXXXX with his extreme financial expenses during his recuperation of his cadavaric transplant on 7-11-11.

XXXXXX is a 51 year old male who has had ESRD since Sept. 1985. During his 20+ years of kidney disease, he has had 2 transplants in the early 1980’s each failing immediately. Meanwhile he has been on hemodialysis at YYYYYY. Remarkably he has always been able to maintain some employment. In the past 5 years, he has worked part-time as an Advertisement Salesman. This employment is commission sales and very flexible, which was ideal with the hemodialysis schedule and occasionally feeling fatigued. However, this job offers no benefits. He has no sick time, no medical leave, and will have no income during his 2 or 3 months recuperative period. He is very worried about these routine living expenses:

- Rent $250
- Utilities $150
- Medications $375
- Loan/charge $300
- Car Payment $340
- Auto Ins. $75
- Food/household $250
- Telephone $55

This third transplant took him (and us) by surprise. He had been on the waiting list for 10+ years, and really had given up hope. He had made provisions with his car payment and his bank loan for disability payments, however he just discovered they are considering this transplant a pre-existing condition, and will not pay!

XXXXXX is single, with 2 adult children. There are really no financial resources available to him within the family. We have discussed fundraising opportunities, however they don’t offer immediate relief, and he isn’t too comfortable with this idea.

I have known XXXXXX for many years while a dialysis social worker in Mexico. I have always found him to be a hard working man during his life-long struggle with kidney disease. Please consider this request.

Sincerely,

Revised June 2011
The forms needed by the facilities to take advantage of MoKP programs are located on the MoKP secure website. They are available to facility staff with user IDs and passwords with social worker or dietitian access privileges. If you need access to the database to obtain forms, contact your facility’s MoKP Coordinator.

Following you will find a copy of all forms available on the MoKP database.
Missouri Kidney Program  
Online Application Worksheet

This form, **with the supporting documentation**, must be sent after you have submitted your on-line application.

Patient Name: ____________________________ SS# _______________________

**Required Documentation:**

1. Signed and Dated Patient Agreement (Form 107A). This page gives MoKP authority to handle issues that may arise with Medicare, MO HealthNet, Private Insurance, etc.
2. Copy of Medicare Card and Medicare Prescription Drug Card (Part D).
3. Copy of front and back of Commercial Insurance Card (Medicare Supplement/Medigap; Employer Group Health; Private/Personal; and/or Medicare Advantage). If policy includes prescription drug coverage the Notice of Creditable Coverage must also be included.

**Other Documentation, if applicable to the requested benefit:**

1. Transportation Worksheet (MoKP form 115) if you are requesting Transportation
2. Prescription Order Form (MoKP form 103) and Consent for Medicare Part D Enrollment (MoKP form 117), if you are requesting routine medications and/or Immunosuppressants.
3. Income and Assets Information with supporting documentation (MoKP form 107), **when the applicant does not qualify for MO HealthNet**.

Your on-line application will be processed in a timely manner (not to exceed 20 calendar days) upon receipt of this form and the supporting documentation.

Submitted by: ______________________________

Social Worker Signature and Date

Facility Name: ______________________________

MoKP Form 101 (revised 7/2017)
Missouri Kidney Program  
Prescription Order Form

Date: _______________________

To: Kilgore’s Medical Pharmacy    Fax #: 573-443-4754
Phone Numbers: Toll Free (866) FIL-MOKP (345-6657)  Local 573-443-8556

From MoKP Facility Name: ________________________ Phone #:________________

Patient Name (PRINT):_________________________________DOB: ___/___/____

Allergies: _________________________________________________________________

Required for Transplant Patients:

Facility Patient Received Transplant: _________________________________
Hospital Discharge Date after Transplant: _________________________________

Diagnosis Codes for Immunos  ICD-10:___________________________

<table>
<thead>
<tr>
<th></th>
<th>Medication</th>
<th>Strength</th>
<th>Directions</th>
<th>Qty</th>
<th>Refills</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

X____________________________  X____________________________
Substitution Permitted  Dispense as Written

X____________________________  X____________________________
Date        Date

PRINT Prescriber’s name: ____________________________________________

Medications are to be sent to: (check one): Facility _______ Patient’s home_______
(Facility must submit a Kilgore’s Prescription Distribution Consent Form if requesting medications be sent to facility.)

Address: _____________________________________________________________
                        (street – no PO boxes)
__________________________________________________________ (city, zip)

Form MoKP 103 - Revised October 5, 2015
MISSOURI KIDNEY PROGRAM
INCOME/ASSET INFORMATION

Complete this page if one of the following is true: (1) you have blind pension MO HealthNet (2) You have MC+ or AFDC – Aid for Dependent Children (3) you do NOT have MO HealthNet coverage (4) you are not financially eligible for MO HealthNet or (5) your spend down is over $1,200/month.

List below all dependents and/or individuals living in your home, including yourself, who are either supported by you or contributing support to the household. Enter all incomes of each individual on the appropriate lines.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Total Monthly Income *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Social Security

Blind Pension

Employment/Pension

Other (list)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Total Monthly Income *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Social Security

Blind Pension

Employment/Pension

Other (list)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Total Monthly Income *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Social Security

Blind Pension

Employment/Pension

Other (list)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Total Monthly Income *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Social Security

Blind Pension

Employment/Pension

Other (list)

*Total Combined Monthly Income for the blanks marked with an ‘*’: $________________

*Total Monthly Income for each person should equal the total of the four amounts on the line immediately following.

**Assets**

Checking Account(s) $______________  CDs/IRAs $______________
Savings Account(s) $______________  Stocks/Bonds/Mutual Funds $______________
Other (money market, credit union accounts, etc.) $______________ Type: ___________

Life Insurance: Cash Surrender value $______________ or circle, if Policy is a irrevocable burial plan.

*DOCUMENTATION REQUIRED: (The following are examples. ALL INCOME AND ASSETS MUST BE DISCLOSED.) Current bank statements, savings account statements, credit union statements, and all current CDs/IRAs/Stocks/Bonds/Mutual Funds/401K statements. Also include a copy of the last (within two years) Federal and State Income Tax returns, including copies of W2s, 1099s and supporting schedules. Your application will not be processed without this information and documentation.

MoKP Form 107 - Revised June 2011
ANNUAL PATIENT AGREEMENT

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING THIS DOCUMENT
(Coverage Period 07/01/2017 – 06/30/2018)

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

• In submitting this application, I guarantee I am a Missouri resident. I guarantee its accuracy and truth with the intent that it be relied upon by the Missouri Kidney Program to verify all facts stated relative to any financial condition or income.

• I UNDERSTAND that as an applicant for Missouri Kidney Program (MoKP) benefit(s), as a consideration of eligibility, I may be required to apply for MO HealthNet, Medicare, health insurance, or other available benefits as deemed necessary to maximize MoKP resources. I UNDERSTAND that the Missouri Kidney Program is a state-funded agency supported by tax dollars and is payer of last resort. Further, that benefit availability may vary among contract facilities and that funding is subject to continued availability through the State of Missouri.

• I AGREE to forward and assign to Missouri Kidney Program or the Centralized Drug Program vendor any and all insurance payments I receive for medication(s) provided by the MoKP Centralized Drug Program. I AGREE to assign all insurance benefits relevant to the Missouri Kidney Program Centralized Drug Program to the MoKP or its designee and to designate the Centralized Drug Program vendor as my primary MO HealthNet pharmacy. I AGREE to allow, by signing of consent forms, MoKP to enroll me in a Medicare Part D Plan best suited to me and the MoKP; and if necessary mail my medications to my dialysis facility.

• I AUTHORIZE the MoKP Centralized Drug Program vendor to release to my insurance company any information including but not limited to diagnosis or treatment records pertinent to payment of my claim.

• I AGREE to inform the MoKP of any changes in household income/dependents, MO HealthNet, Medicare, or private insurance coverage/benefits, or change of address within ten (10) days of such change.

• I AUTHORIZE the MoKP to verify any and all information and documentation submitted pursuant to this and any future application/request for benefits. I UNDERSTAND that it is against the law to obtain or attempt to obtain benefits to which I am not entitled. Any false claim, statement, or concealment of any material fact whatever, in whole or in part, may subject me to civil and /or criminal prosecution.

• I AUTHORIZE and REQUEST the Missouri Division of Family Services to release information and documentation to the Missouri Kidney Program regarding my MO HealthNet case, including but not limited to type and dates of coverage, reason for rejection or closing, and household income and resources.

• I AUTHORIZE and REQUEST my insurance company/carrier/administrator and/or medicine provider to release/disclose information and documentation to the Missouri Kidney Program (MoKP) including but not limited to verification of coverage, dates of coverage, summary of medical and prescription drug benefits, and premium amount. This request is pursuant to my application/eligibility for MoKP benefit(s). A photo copy of this signed authorization shall be as valid as the original.

• I AUTHORIZE and REQUEST my current and past employer(s) to release information and documentation to the Missouri Kidney Program including but not limited to employment history, health insurance coverage/premium amount, and wage/salary information.

• I AUTHORIZE and REQUEST the Missouri Department of Revenue to release my/our confidential income tax records to the Missouri Kidney Program. The Director of Revenue and Department personnel are hereby released from any and all liability pursuant to unauthorized disclosure of confidential tax information resulting from release of information under section 32.057, RSMo, or any other applicable confidentiality statement. This authorization is valid until revoked; any revocation must be in writing.

• I UNDERSTAND that information submitted by me will otherwise be treated as confidential.

__________________________________________            ________________________
Patient signature                                                           Date

__________________________________________            _________________________
Social Security Number                                                 Date of Birth

Missouri Kidney Program Form 107A (revised 9/2003)
MISSOURI KIDNEY PROGRAM

Application Renewal Form

Name: __________________________________________
Address: __________________________________________
Phone Number: __________________________________________
County: __________________________________________
Social Security #: __________________________________________
Date of Birth: __________________________________________
Medicare #: __________________________________________
Effective Date: __________________________________________
Existing Insurance: __________________________________________

PLEASE PROVIDE THE FOLLOWING INFORMATION:

MEDICARE Number: ________________ MEDICAID Number:_______________________
Additional Insurance Coverage________________________________________________

Please enclose a copy of the front and back sides of all insurance cards.

Please list the names of the people living in your household.
_________________________________________________________________________

Please provide documentation of current household income, including social security, pension, disability, veteran benefits, unemployment, AFDC, Workman's Compensation, interest and any additional income sources. If you file taxes, send a copy of your most recent Federal Income Tax Return (1040) including all attached schedules, along with the W-2 form. Please also include a copy of your most recent Missouri State tax return and attached schedules.

Please list current balances for the following assets:

Checking Account(s) $________________ Savings Account(s) $____________
CD's/IRA's $____________ Stocks/Bonds $__________
Others (Please list) $________________

- Please send copies of current bank statements for these accounts.

Revised 10-10-16
**Transplant Facilities:** complete this form when a recipient of the Missouri Kidney Program is transplanted at your facility; and/or a Missouri Kidney Program transplant recipient is tracked by your facility but was transplanted at a facility other than yours; and/or loses their transplant or expires.

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex: M F (Please Circle One)</td>
<td></td>
</tr>
<tr>
<td>Ethnic Origin: Asian African American Native American Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>Hispanic White (Please Circle One)</td>
<td></td>
</tr>
<tr>
<td>Birth date:</td>
<td>______________________</td>
</tr>
<tr>
<td>Social Security Number:</td>
<td>______________________</td>
</tr>
<tr>
<td>Transplant Date:</td>
<td>______________________</td>
</tr>
<tr>
<td>Transplant Facility: (if known)</td>
<td>______________________</td>
</tr>
<tr>
<td>Donor Type: (circle one) Deceased Donor Living Unrelated Donor Living</td>
<td></td>
</tr>
<tr>
<td>Related Donor</td>
<td></td>
</tr>
<tr>
<td>Failure Date:</td>
<td>______________________</td>
</tr>
<tr>
<td>Receiving Facility: (if known)</td>
<td>______________________</td>
</tr>
<tr>
<td>Date of Death:</td>
<td>______________________</td>
</tr>
<tr>
<td>Date Facility Lost Contact:</td>
<td>______________________</td>
</tr>
<tr>
<td>Zip Code of Residence:</td>
<td>______________________</td>
</tr>
</tbody>
</table>

This form may be faxed OR mailed (Do Not Do Both).

Prepared by: ______________________________________________
Facility: ______________________________________________
Telephone: ______________________________________________
Missouri Kidney Program
Facility Staff Travel
Trip Expense Reimbursement Request

Traveler: __________________________________________________________

Traveler's Facility: __________________________________________________

Purpose of Trip: _____________________________________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Destination From</th>
<th>Destination To</th>
<th>Breakfast Amt</th>
<th>Lunch Amt</th>
<th>Dinner Amt</th>
<th>Lodging Amt</th>
<th>Other Amt</th>
<th>Total for the Day Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Used Personal Car: _______ miles at _____ cents per mile = auto allowance

Total Amount Payable: $________________________

I certify that this claim is correct and just, that no part of the same has been paid, that the above expense was necessary to the business of the Missouri Kidney Program, that I have made payment therefore and that I have not been nor will be reimbursed therefore from any other source.

Signature: ___________________________________________ Date: ____________

Title: ____________________________________________

MoKP Form Revised Jan 2012
MoKP Transportation Worksheet

Date __________

Patient SS#: ______________________________

Patient Name: _____________________________

Facility Name: _____________________________

Social Worker: _____________________________

Mode of Transportation being requested (check one)

☐ Mileage: # of round trip miles ____________
  ☐ Calculation based on MapQuest (circle one) yes  no
  ☐ Calculation based on __________________________

☐ Public Transportation (enter amount, if applicable)
  ☐ Share-A-Fare $______________ (daily round trip)
  ☐ Call-A-Ride $______________ (daily round trip)
  ☐ City Bus Line (ie, bus passes) $__________________

☐ Vendor Transportation
  ☐ Quote one: Vendor _____________________ $__________
    (daily round trip)
  ☐ Quote two: Vendor _____________________ $__________
    (daily round trip)

Comments: _______________________________________

________________________________________________________________________

Approved by: ____________________________________________

Transportation Effective Date: ____________________________
Facility Name: ________________________________________________________________

Facility Address: _____________________________________________________________

Phone Number: __________________________________________________________________

Fax Number: ___________________________________________________________________

Patient Name: __________________________________________________________________

Patient Address: (street) _________________________________________________________

(town, zip code) __________________________________________________________________

Miles (one way) - round to nearest tenth: ______________________ x 2 __________________

Month/Year of Treatment: _______________________________________________________________________________

<table>
<thead>
<tr>
<th>Date of Treatment (circle appropriate dates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>21</td>
</tr>
<tr>
<td>26</td>
</tr>
</tbody>
</table>

Number of treatments: ____________________________________________________________

Amount of reimbursement -
Total Miles x $.23 (as of January 1, 2015): $ ________________________________

Additional comments/special circumstances/etc (example: mileage is for one-way only)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Patient Signature/Date: ____________________________________________________________

I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge.

Social Worker Signature/Date: ______________________________________________________

I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge.

For facility use only: (if checks are mailed to the patient, indicate mailed)
Patient initials/date that check was received from facility

MoKP Form 116 (updated Jan 2015)
Please complete information for enrollment in a Part D - prescription drug plan.

Full Name: _____________________________
LAST NAME (include suffix: Jr, Sr, II, etc) _______________________ FIRST NAME _______________________ MIDDLE INITIAL _______________

Address: __________________________________________________________________________

City: _______________________________

Zip Code: _______________________________ County: __________________________

If different, Physical Address if mail is PO or address __________________________________________

Home Phone Number: ____________________________ Cell Phone Number: _____________________

Date of birth: _______________________ (Month/Day/Year)

List only the medications that you purchase from a pharmacy other than Kilgore’s Medical Pharmacy. If necessary, attach another sheet of paper.

<table>
<thead>
<tr>
<th>Drug Name / Dosage</th>
<th>Quantity</th>
<th>Days Supply (per month, per week, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• I will notify Missouri Kidney Program of any changes to the above information.
• I authorize the Missouri Kidney Program to enroll me in the Medicare Part D Prescription Drug Plan that meets my medication needs.
• I acknowledge that Kilgore’s Medical Pharmacy will notify the Missouri Kidney Program when it is necessary to change my prescription drug plan enrollment.
• I understand this consent form is valid through October 31, 2018.

Signature: ___________________________________________ Date: _____________________

Guardian or Relationship if signing for patient: ____________________________

MoKP# ____________________________
Medicare # ____________________________
Part A Date: ____________________________
Current PDP: ____________________________
Comments: ____________________________

Coordinator: ____________________________
Social Worker: ____________________________
Part B Date: ____________________________

Missouri Kidney Program Form 117 (revised 7/2017)
MOHealthNet Application Cover Sheet

Client/applicant name: ________________________________

Dialysis / transplant facility: _________________________

Social Worker: _____________________

Social worker phone: ____________________

Social worker fax: _________________

MOKP status:

Client currently on MOKP

MOKP application pending

Completing MOKP application along with MOHealthNet application

Not applying for MOKP, please forward MOHealthNet application to the local county FSD office.

PLEASE ATTACH THIS FORM TO THE MOHEALTHNET APPLICATION WHEN MAILING OR FAXING TO THE MOKP/STATE FSD WORKER. (Melissa Krapf).

Melissa Krapf
Fax Number: 573-884-5276
Phone Number: 866-665-7373
Address: MoKP FSD Case Worker
201 Business Loop 70 West
AP Green Building Suite 111
Columbia, MO 65201

Revised 10-10-16
MISSOURI KIDNEY PROGRAM
APPLICATION FOR ASSISTANCE

A.P. Green Building - Suite 111
201 Business Loop 70 West
COLUMBIA, MO 65211-8180

1-800-733-7345
(573) 882-2506

Facility Access: https://mokp.missouri.edu/mokp_web

Public Access: www.hsc.missouri.edu/~mokp

Please read each item carefully before you answer it. The answers you give will be used to determine your eligibility for MoKP benefits. A friend, relative, or the social worker may assist you in completing this application.

This application must be submitted to MoKP by the social worker.

DO NOT fax Application

Entered in EBASE: ___________________________ Date ___________ Initials ___________

Qc'd: ___________________________ Date ___________ Initials ___________

Revised 4/2007
APPLICATION FOR MISSOURI KIDNEY PROGRAM ASSISTANCE
COMPLETE ALL BLANKS • PLEASE PRINT CAREFULLY • USE BLACK INK

Name ________________________________  Sex: □ Male □ Female
Use Full Legal Name, No Nicknames

Permanent Address ________________________________
Street/Route #/P.O. Box __________ City ________ Zip Code ________

County (If St. Louis, indicate city or county) __________ Telephone Number (include Area Code) __________

Social Security Number _______ - _______ - _______ Date of Birth _________

Marital Status (check one): □ Married □ Single Number of Dependents (including yourself) ________

Please circle one of the following ethnic origins:
Asian, African American, Native American, Pacific Islander, Hispanic, White

- MEDICARE # __________ - _______ - _______ - _______ EFFECTIVE DATE (Part B) __________
ATTACH COPY OF MEDICARE CARD AND MEDICARE PRESCRIPTION DRUG CARD (PART D)

If not eligible for Medicare, indicate reason __________

- MEDICAID # __________

If not eligible for Medicaid, indicate reason __________

- Are you, or your spouse, eligible for military benefits? You □ YES □ NO
Your Spouse □ YES □ NO

- Are you receiving MC+ (AFDC) benefits? (complete page 3) □ YES □ NO

- Are you receiving a blind pension benefit? (complete page 3) □ YES □ NO

- OTHER INSURANCE __________

TYPE OF COVERAGE: □ Medicare Supplement/Medigap □ Employer Group □ Private/Personal □ Medicare Advantage

IF DIFFERENT FROM PATIENT:
NAME OF POLICYHOLDER ___________________________ POLICY NO. __________________
DATE OF BIRTH __________________ GROUP NO. __________________
SOCIAL SECURITY # __________________ PHONE NO. __________________
EFFECTIVE DATE __________________

ATTACH COPY (FRONT AND BACK) OF INSURANCE CARD, BENEFIT SUMMARY PAGE, AND
NOTICE OF CREDITABLE COVERAGE IF POLICY INCLUDES PRESCRIPTION DRUG COVERAGE

DO NOT WRITE IN THIS SPACE

MEDICAID VERIFICATION

CON _______ CONB _______ CONN _______ CONF _______ CONR _______
SD _______ $ _______ QMB _______ SLMB _______ 

date verified: ________
initials: ________
THIS PAGE IS TO BE COMPLETED BY THE SOCIAL WORKER

PATIENT CURRENT STATUS:  □ Dialysis  □ Transplant

- If Dialysis: Date of first dialysis at your facility __________________________ (MM-DD-YYYY) [Line 24 from Medicare form 2728]
- If Transplant: Date of current transplant __________________________ (MM-DD-YYYY)
  Type of transplant, circle one:  CAD  LRD  LUR

Above info based on ESRD Medical Evidence Report - Form CMS 2728

TYPE OF ASSISTANCE REQUESTED:

□ TRANSPORTATION: Estimated $ ___________ /month  (Include MoKP Form 115, Transportation Worksheet)

□ ROUTINE MEDS*  *Include the following forms:
  MoKP 103, Prescription Order Form
  MoKP 117, Consent for Medicare Part D Enrollment

□ IMMUNOSUPPRESSANTS*

□ INSURANCE PREMIUMS: Private: $ ___________ /month

□ INSURANCE PREMIUMS: Medicare Part B: $ ___________ /month

□ NUTRITIONAL SUPPLEMENTS

□ SECTION I - PATIENT CARE

JUSTIFICATION FOR FUNDING (justification should include both financial and socio-economic need)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Date

Social Worker Signature

Facility

THIS APPLICATION WILL NOT BE PROCESSED UNLESS THIS SECTION IS COMPLETE AND INSURANCE CARDS AND PRESCRIPTION ORDER FORM (if applicable) ARE ATTACHED, SIGNED AND DATED. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.
**INCOME/ASSET INFORMATION**

Complete this page if one of the following is true:
- You have Blind Pension Medicaid
- You have MC+ or AFDC - Aid for Dependent Children
- You do NOT have Medicaid coverage
- You are not financially eligible for Medicaid
- Your spend down is over $1,000.00/month

List below all dependents and/or individuals living in your home, including yourself, who are either supported by you or contributing support to the household. Enter all incomes of each individual on the appropriate lines.

**INCOME** (Gross Monthly Income)*:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Soc Security</th>
<th>Blind Pension</th>
<th>Employment/Pension</th>
<th>Other (list)</th>
<th>Total Monthly Income*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
</tr>
</tbody>
</table>

**TOTALS**

<table>
<thead>
<tr>
<th>Soc Security</th>
<th>Blind Pension</th>
<th>Employment/Pension</th>
<th>Other (list)</th>
<th>Total Monthly Income*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
<td>$___</td>
</tr>
</tbody>
</table>

**ASSETS***:

List below current balances for each asset type and attach a copy of current statements for each account or asset to support the amounts. For example: If you have three (3) CDs/IRAs, list the total of all three (3) and attach a copy for each of the three CDs/IRAs.

Checking Account(s) $___
Savings Account(s) $___
CDs/IRAs $___
Stocks/Bonds/Mutual Funds $___
Life Insurance: Cash Surrender value $___ or circle, if Policy is an irrevocable burial plan
Others (money market, credit union accounts, etc.) $___
Type: ___

*DOCUMENTATION REQUIRED: (The following are examples. ALL INCOME AND ASSETS MUST BE DISCLOSED.)

Current bank statements, savings account statements, credit union statements, and all current CDs/IRAs/Stocks/Bonds/Mutual Funds statements. Also include a copy of the last (within two years) Federal and State Income Tax returns, including copies of W2's, 1099's and supporting schedules. Your application will not be processed without this information and documentation.
MOKP CANNOT ESTABLISH ELIGIBILITY WITHOUT ONE
OF THE SIX BOXES CHECKED

☐ Diabetes Type I

☐ Diabetes Type II

☐ Hypertension

☐ Diabetes (Type I) [and] Hypertension

☐ Diabetes (Type II) [and] Hypertension

☐ Some diagnosis other than the above
Need help with your application?
Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY users can call: 1-800-735-2966. If you are blind or visually impaired and would like information regarding Rehabilitation Services for the Blind, please call 1-800-592-6004.

¿Necesita ayuda con su aplicación?
Llámenos al 1-855-373-4636. Si necesita ayuda en una lengua que no sea el inglés, dígale al representante de servicio al cliente la lengua que usted necesite. Los usuarios de teléfonos de texto pueden llamar al: 1-800-735-2966. Si usted es ciego o tiene una discapacidad visual y desearía información sobre los Servicios de Rehabilitación para Invidentes, por favor llame al 1-800-592-6004.
I, the above named applicant, apply for MO HealthNet under the laws of the state of Missouri.

Check any of these that apply to you or your spouse if your spouse wants coverage.

☐ I/We are over age 65.

☐ I/We are disabled and get Social Security disability or SSI.

☐ I/We are disabled and do not get Social Security disability or SSI.
   If you check this box, also fill out Appendix A to help determine if you meet the disability requirements.

☐ I/We are blind or visually impaired.
   If you check this box, also fill out section 8 of this application to see if you qualify for Blind programs.

☐ I/We live in a nursing home or similar facility.
   If you check this box, please list:

☐ I/We are age 63 and over and need in-home nursing care.
   If you check this box, also fill out Appendix B if you're married, and one of you either lives in a nursing home or needs skilled nursing care at your home.

☐ I/We need help paying for Medicare premiums and co-insurance costs.

☐ I/We work and pay income taxes, and want coverage under the Ticket to Work program.
   If you check this box, this may let you qualify for MO HealthNet by paying a premium.

☐ I/We need help with medical bills from the last 3 months.

☐ I/We have a conservator, guardian, attorney-in-fact, or another person to represent us.
   If you check this box, fill out Appendix C to name an authorized representative, or provide conservator, guardian, or power of attorney documents. Then fill out the representative’s contact information on page 6.

All applicants must fill out sections 2 through 7.
SECTION 2: Your Household

Below, list your spouse first, then anyone who lives with you, or would be if you weren't in a nursing home.

<table>
<thead>
<tr>
<th>NAME (FIRST, MIDDLE, LAST)</th>
<th>(MAIDEN)</th>
<th>HISPANIC Y/N (optional)</th>
<th>RACE* (optional)</th>
<th>SEX</th>
<th>RELATIONSHIP TO YOU (spouse, son, sister, friend)</th>
<th>DATE OF BIRTH</th>
<th>CHECK (✓) IF THEY'RE APPLYING</th>
<th>SOCIAL SECURITY NUMBER (if applying)</th>
<th>PLACE OF BIRTH (if applying)</th>
</tr>
</thead>
</table>

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

ARE YOU MARRIED AND LIVE WITH YOUR SPOUSE, OR LIVED WITH YOUR SPOUSE WHEN YOU ENTERED A NURSING HOME?

☐ YES  ☐ NO

If yes, we need your spouse's income and resource information, but your spouse doesn't have to apply for coverage.

ENTER THE DATE YOU GOT MARRIED

SECTION 3: Money Available To You

ARE YOU OR YOUR SPOUSE A PARTY TO A TRUST?

☐ YES  ☐ NO

If yes, we must review the entire trust. You must provide it and fill out below:

NAME AND DATE OF TRUST

WHAT IS YOUR OR YOUR SPOUSE'S ROLE IN THE TRUST?

We have the following resources (include trust assets you can access): Check (✓) all that apply:

[ ] Money
[ ] Buildings or units
[ ] Stocks and bonds
[ ] Computers
[ ] Jewelry
[ ] Antiques
[ ] Furniture
[ ] Motor vehicles
[ ] Other

Total value: $________

We have any other assets (include trust assets you can access): Check (✓) all that apply:

[ ] Money
[ ] Buildings or units
[ ] Stocks and bonds
[ ] Computers
[ ] Jewelry
[ ] Antiques
[ ] Furniture
[ ] Motor vehicles
[ ] Other

Total value: $________

* Race can be selected if applicable.

** Include value in $1,000 increments.
**SECTION 4: Your Income and Expenses**

We receive income from the following. Check (√) all that apply.

<table>
<thead>
<tr>
<th>UNEARNED INCOME</th>
<th>WHO GETS IT?</th>
<th>WHERE IS IT FROM?</th>
<th>AMOUNT PER MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Social Security</td>
<td>N/A</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Claim number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Supplemental Security Income (SSI)</td>
<td>N/A</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ Trusts and Annuities</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ Non-VA pensions, Retirement, and Disability</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ Interest or Dividends</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ Unemployment compensation</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ Worker’s compensation</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ Military branch retirement pension</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ Worker’s compensation</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ Money from friends or family</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ VA Payments (Check all that apply)</td>
<td>N/A</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>VA Pension</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Disability Compensation</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>DIC Compensation</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Aid &amp; Attendance</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Homebound Allowance</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Medical Reimbursement</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>□ Other (explain where the money comes from and the amount)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EARNED INCOME</th>
<th>EMPLOYER</th>
<th>INCOME BEFORE TAXES</th>
<th>HOW OFTEN ARE YOU PAID THIS AMOUNT? (CHECK ONE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ I am employed</td>
<td></td>
<td></td>
<td>□ WEEKLY □ EVER 2 WEEKS □ MONTHLY</td>
</tr>
<tr>
<td>□ My spouse is employed</td>
<td></td>
<td></td>
<td>□ WEEKLY □ EVER 2 WEEKS □ MONTHLY</td>
</tr>
<tr>
<td>□ ______________________ is employed</td>
<td></td>
<td></td>
<td>□ WEEKLY □ EVER 2 WEEKS □ MONTHLY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SELF-EMPLOYMENT</th>
<th>WHO IS SELF-EMPLOYED?</th>
<th>TYPE OF BUSINESS</th>
<th>MONTHLY INCOME AFTER TAXES &amp; EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Someone in my house or I am self-employed</td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

**FILL OUT THIS SECTION ONLY IF YOU'RE MARRIED AND LIVING IN A NURSING HOME**

My spouse and I pay these costs

<table>
<thead>
<tr>
<th>TYPE OF COST</th>
<th>AMOUNT</th>
<th>HOW OFTEN DO YOU PAY FOR IT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Utilities (not including phone)</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>□ Mortgage</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>□ Rent</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>□ Real Estate Taxes</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>□ Homeowner's Insurance</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>□ Condo Fees</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>□ Phone</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>
### FILL OUT THIS SECTION IF YOU PAY ANY CHILD SUPPORT OR ALIMONY PAYMENTS

<table>
<thead>
<tr>
<th>CASE NUMBER</th>
<th>AMOUNT PER MONTH</th>
<th>WHAT STATE DOES THE ORDER COME FROM?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

### SECTION 5: Your Citizenship and Residency

1. I/we are residents of Missouri and plan to stay in Missouri
   - [ ] YES  [ ] NO

2. All applicants are U.S. Citizens
   - [ ] YES  [ ] NO
   If no, fill out the following:

<table>
<thead>
<tr>
<th>NAME OF NON-CITIZEN APPLICANT</th>
<th>IMMIGRATION STATUS</th>
<th>REGISTRATION NUMBER</th>
<th>DATE OF ENTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. I/we agree to apply for other benefits I/we may be able to get (SSI, SSL, VA, etc)
   - [ ] YES  [ ] NO
   If no, you may not be able to get MO HealthNet.

### SECTION 6: Your Personal Property

#### TRANSFER OF PROPERTY OR MONEY

Has anyone in your home sold or given away money, vehicles, or property within the last five years?
- [ ] YES  [ ] NO
   If yes, fill out below:

<table>
<thead>
<tr>
<th>MONEY/VEHICLE/PROPERTY SOLD OR GIVEN</th>
<th>DATES SOLD OR GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSON IT WAS SOLD OR GIVEN TO</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VALUE OF MONEY/VEHICLE/PROPERTY</th>
<th>AMOUNT RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

#### VEHICLES

List cars, trucks, vans, motorcycles, recreational vehicles, and others.
- [ ] I/we don't own a vehicle.

<table>
<thead>
<tr>
<th>MAKE/MODEL</th>
<th>YEAR</th>
<th>OWNER</th>
<th>VALUE</th>
<th>AMOUNT OWED</th>
<th>HOW IS IT USED?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

#### REAL ESTATE PROPERTY

I/we own or am buying real estate.
- [ ] YES  [ ] NO
   If yes, provide a copy of the deed

<table>
<thead>
<tr>
<th>ENTER THE ADDRESS OR LOCATION (FOR MOBILE HOMES, SEE PERSONAL PROPERTY BELOW)</th>
<th>OWNER</th>
<th>VALUE</th>
<th>AMOUNT OWED</th>
<th>HOW IS IT USED? (HOME, RENTAL, ACREAGE, OTHER)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PERSONAL PROPERTY

I/we own the following types of personal property (include trust assets that you have access to). Check (✓) all that apply.

<table>
<thead>
<tr>
<th>TYPE OF PROPERTY</th>
<th>HOW MANY?</th>
<th>DESCRIPTION</th>
<th>VALUE</th>
<th>AMOUNT YOU OWE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mobile Home</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check here if this is your home</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farm machinery (include tractors)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farm livestock</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farm grain or produce in storage</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Business equipment</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trailer (utility, boat, etc.)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Boat</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
**SECTION 7: Your Insurance**

If we have life insurance:
- [ ] Yes  [ ] No

If yes, fill out below:

<table>
<thead>
<tr>
<th>PERSON INSURED</th>
<th>INSURANCE COMPANY</th>
<th>POLICY NUMBER</th>
<th>CASH VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

If we have Medicare:
- [ ] Yes  [ ] No

If yes, list the names of the people who have Medicare:

If we have long-term care insurance:
- [ ] Yes  [ ] No

If yes, fill out below:

<table>
<thead>
<tr>
<th>NAME OF PERSON WITH LONG-TERM CARE INSURANCE</th>
<th>INSURANCE COMPANY</th>
<th>POLICY NUMBER</th>
<th>PREMIUM (per month)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

If we have other health insurance:
- [ ] Yes  [ ] No

If yes, fill out below:

<table>
<thead>
<tr>
<th>PERSON INSURED</th>
<th>INSURANCE COMPANY</th>
<th>TYPE OF COVERAGE</th>
<th>POLICY NUMBER</th>
<th>PREMIUM (per month)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

If you can get cash payments and have an account, do you want the cash to go directly into your account?
- [ ] Yes, I want direct deposit  [ ] No, I do not want direct deposit.

**Only fill out this section (Section 8) if you want Blind Pension or Supplemental Aid to the Blind.**

**SECTION 8: Blind Pension and Supplemental Aid to the Blind**

1. Do you have a sighted spouse or parent?  [ ] Yes  [ ] No
2. Do you ask or beg for money?  [ ] Yes  [ ] No
3. Have you applied or do you agree to apply for Supplemental Security Income (SSI) as a condition of eligibility?  [ ] Yes  [ ] No
4. Have you had eye surgery within the last five years?  [ ] Yes  [ ] No
5. If you are younger than 75, are you willing to have medical treatment or an operation to correct your blindness?  [ ] Yes  [ ] No
6. Would you be willing to do job training or work at a job for which you are suited?  [ ] Yes  [ ] No
7. Do you have an eye doctor (either an ophthalmologist or an optometrist)?  [ ] Yes  [ ] No

If yes, fill out below:

**Facility and Doctor Name**

**Address (House number, Street or Rural Route, PO Box)**

**City, State, Zip Code**

**Date of Last Eye Exam**

**Date of Next Appointment**

**MO 868-3046 (6-15) Page 5 of 7 Permanent IM-14A (6/15)**
RIGHTS AND RESPONSIBILITIES: Please read carefully and sign below

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

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 report any changes in circumstances within ten days of when they happen.

I/we understand that I/we must provide Social Security Numbers (SSN) of all persons applying for MO HealthNet. The SSN is used to determine eligibility and verify information (Section 1137 of the Social Security Act).

I/we understand that I/we are entitled to fair and equal treatment regardless of race, color, religion, national origin, sex, ancestry, age, sexual orientation, veteran status, or disability.

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.

If signing electronically: By entering my name, I have agreed to submit this application by electronic means. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

By signing this application on paper or electronically, you are giving us permission to deliver, or cause to be delivered, phone calls to you regarding your case from an automated dialing system at the primary phone number you provided on Page 2. You do not have to consent to this as part of your application. If you want to opt out of getting these calls, check here: ☐

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

<table>
<thead>
<tr>
<th>SIGNATURE OF APPLICANT</th>
<th>DATE</th>
<th>SIGNATURE OF SPOUSE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE ON BEHALF OF APPLICANT</td>
<td>DATE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IF YOU ARE SIGNING ON THE APPLICANT’S BEHALF, PLEASE IDENTIFY YOUR RELATIONSHIP TO THE APPLICANT:

☐ Guardian or Conservator  ☐ POA/Attorney-in-fact  ☐ Estate representative

☐ Authorized representative (complete form IM-6AR in Appendix C)  ☐ Family member

☐ Attorney representing applicant (please provide Entry of Appearance)

Please print your name and contact information below.

REPRESENTATIVE NAME (FIRST, MIDDLE, LAST)  

REPRESENTATIVE MAILING ADDRESS

CITY, STATE, ZIP CODE

MO 856-3846 (6-15)  

PAGE 7 OF 7  

PERMANENT  IM-114A (08/15)
We hereby apply for Medicare cost savings under one of the following programs:
- Qualified Medicare Beneficiary
- Specified Low Income Medicare Beneficiary
- Qualifying Individuals

INSTRUCTIONS: Read the application carefully, answer each question completely and accurately. Please print in black or blue ink. Attach additional pages if needed. If you are unable to complete this application, you may have a friend, relative or someone else help you. When your application is received, it will be reviewed and if additional information is needed, you will be contacted.

Sign, date, and mail or deliver the application to the Division of Family Services office located in your county of residence. You may call 1-800-392-1251 for the address of the Division of Family Services in your county.

| COMPLETE THE FOLLOWING INFORMATION FOR YOU AND YOUR SPOUSE (IF MARRIED) |
| NAME | BIRTH DATE | SEX | RACE | SOCIAL SECURITY NUMBER | US CITIZEN |
| ($) SELF | | | | | |
| SPouse | | | | | |

IF YOU OR YOUR SPOUSE ARE NOT A CITIZEN, PLEASE PROVIDE YOUR IMMIGRATION STATUS AND REGISTRATION NUMBER AND DATE OF ENTRY

ARE YOU APPLYING FOR MEDICARE SAVINGS FOR YOUR SPOUSE, TOO?
- YES
- NO

DO YOU OR YOUR SPOUSE HAVE OTHER HEALTH INSURANCE?
- YES
- NO

IF YES, COMPLETE THE FOLLOWING:

| SELF |
| INSURANCE COMPANY | POLICY NUMBER | TYPE OF COVERAGE |
| | | |

| SPOUSE |

DO YOU OR YOUR SPOUSE OWN ALL OR PART OF ANY REAL ESTATE IN WHICH YOU DO NOT LIVE?
- YES
- NO

IF YES, COMPLETE THE FOLLOWING:

| ADDRESS | VALUE | AMOUNT OWED | WHO HOLDS THE MORTGAGE | HOW IS IT USED? |
| | | | | |

DO YOU OR YOUR SPOUSE OWN A CAR, TRUCK, MOTORCYCLE, BOAT, TRAILER OR OTHER VEHICLE?
- YES
- NO

IF YES, COMPLETE THE FOLLOWING:

| TYPE OF VEHICLE | OWNER | YEAR | MAKE | MODEL | VALUE | AMOUNT OWED |
| | | | | | | |

MO 885-3805 (6-03)
IM-IDMB (6-03)
List all resources (assets) owned by you or your spouse. Include all checking, savings account, stocks, certificates of deposit, annuities, business or farm equipment, jewelry (other than your wedding/engagement rings, watches or costume jewelry), bonds, trust funds, burial plots or other assets.

<table>
<thead>
<tr>
<th>TYPE OF RESOURCE</th>
<th>ACCOUNT NUMBER</th>
<th>VALUE OR BALANCE</th>
<th>NAME OF BANK, ETC.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you or your spouse have a life insurance policy or funeral plan?
- Yes
- No
- If yes, complete the following:

<table>
<thead>
<tr>
<th>PERSON INSURED</th>
<th>POLICY OWNER</th>
<th>INSURANCE COMPANY</th>
<th>POLICY NUMBER</th>
<th>FACE VALUE</th>
<th>TYPE OF INSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List all types of earnings and income that you and your spouse receive. (such as wages, self-employment, Social Security, SSI Benefits, Veterans Benefits, Railroad Retirement, Unemployment Compensation, or Pensions, Interest, Dividends, Annuity, Other) List the income before deductions (such as taxes, insurance, etc.).

<table>
<thead>
<tr>
<th>PERSON RECEIVING INCOME</th>
<th>TYPE OF INCOME</th>
<th>SOURCE OF INCOME</th>
<th>AMOUNT</th>
<th>HOW OFTEN RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Please read carefully and sign below
- You are entitled to fair and equal treatment regardless of your age, sex, race, color, handicap, religion, creed, national origin or political belief.
- If you disagree with the decision concerning your eligibility, you may request a fair hearing by contacting the local Family Services office within 90 days of the eligibility decision.
- I agree that I must provide Social Security Numbers (SSN) of all persons applying. The SSN is used to determine eligibility and verify information (Section 1137 of the Social Security Act).
- I agree my statements and information may be verified.
- I will report any changes in circumstances within TEN DAYS of when they happen.
- I know it is against the law to obtain or attempt to obtain benefits to which I/we am 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 UNDERSTAND that the State of Missouri may file a claim against my/our estate to recover any assistance received.
- I agree medical information about me can be released if needed to administer this program.
- I hereby authorize all providers of medical benefits who render services or merchandise to me/us under Medicaid to release all records regarding such services or merchandise to the Department of Social Services and its representatives.
- Provided I am found eligible for Medicaid 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, etc.) for services paid by the state.

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

<table>
<thead>
<tr>
<th>SIGNATURE OF APPLICANT</th>
<th>DATE</th>
<th>SIGNATURE OF SPOUSE</th>
<th>DATE</th>
</tr>
</thead>
</table>
**Missouri Department of Social Services**  
**Family Support Division**  
**MO HealthNet Spend Down Provider Form**

**Provider Instructions:** Please assist your patient by completing the following information. By completing this form, you are verifying medical expenses have been incurred and are owed by your patient. The “Total Daily Expense Patient is Responsible to Pay” column should reflect the patient’s incurred expenses for which they are personally responsible to pay.

**ATTENTION:** All fields on this document are **required** to be completed, unless an attachment(s) verifying the required information for the incomplete field is provided.

<table>
<thead>
<tr>
<th>Patient Name (Print):</th>
<th>MO HealthNet Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check One:</th>
<th>Doctor</th>
<th>Pharmacy</th>
<th>Hospital:</th>
<th>In-patient</th>
<th>Out-patient</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Service Description</th>
<th>Procedure Code</th>
<th>Name of Liable Third Party(s)</th>
<th>Total Amount of Charge</th>
<th>Amount of Expense Billable to Third Party</th>
<th>Write off or Other Discount (i.e. Indigent Waiver)</th>
<th>Total Daily Expense Patient is Responsible to Pay</th>
<th>Total Amount Billable to State Only Funds (i.e. DMH, DHSS contracts)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXAMPLE:**  
08/01/2012  
CPR Medication Services  
90882  
DMH  
$80.00  
$80.00  
$0.00  
$0.00  
$80.00

**BY COMPLETING AND SIGNING THIS DOCUMENT, YOU ARE ATTESTING TO THE ACCURACY OF THE INFORMATION PROVIDED AND THAT THE PATIENT WILL BE BILLED FOR THE AMOUNT DUE. PLEASE INITIAL HERE IF THIS FORM IS COMPLETED BASED ON A GOOD FAITH ESTIMATE OF THE EXPENSES OWED/BILLABLE TO PATIENT: ____________

**THE FOLLOWING INFORMATION IS REQUIRED TO BE COMPLETED BY THE PROVIDER:**

<table>
<thead>
<tr>
<th>Name of Provider or Authorized Employee Completing Form (Please print):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of person completing form:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

This form is not considered acceptable verification of allowable spend down expenses without completion of the required fields and attestation. This form does not replace the responsibility of the provider to bill the patient or submit a claim to MO HealthNet Division.

MO 886-4501 (9-12 rev)
INSTRUCTIONS FOR THE SPEND DOWN PROVIDER FORM

Purpose: The “Spend Down Provider Form” is used by providers to verify medical expenses incurred by patients when an actual bill is not available.

Patient Name: This field is completed with the name of the patient who has incurred billable medical expenses.

MO HealthNet Number: This field is completed with the patient’s MO HealthNet number or DCN. (This number is the same number on the patient’s MO HealthNet card).

Provider Name: The provider is to list the name as it appears on their contract with MHD. Providers not contracted with MHD are to list their name as it appears on Income Tax documents.

Check One: The provider is to mark which type of service was provided to the patient.

Date of Service: Enter the date of service for the incurred medical expense. (If more than one service is performed on a specific date, the services can be combined if an itemized statement is attached to this form.)

Service Description: This field is completed with a description of the medically necessary service provided to the patient as defined under RSMo Section 208.152.

Procedure Code: This field is completed with the procedure code used for submission of claims to MO HealthNet Division, located at http://manuals.momed.com/manuals.

Name of Liable Third Party(s) (TPL): This field is completed with the name of any third party payers/insurance known to the provider. If there are multiple third party payers, each TPL must be listed separately. Enter “N/A” if there is no known TPL.

Total Amount of Charge: This field is completed with the TOTAL amount of charges incurred by the participant.

Amount of Expense Billable to Third Party: This field is completed with the amount of expenses owed by or billed to liable third party. MO HealthNet is a payer of last resort. Enter $0 if no TPL.

Write off or Other Discount: This field is completed with the amount of incurred expenses written off or any discounts given that will not be billed to the patient. Enter $0 if no discounts.

Total Daily Expense Patient is Responsible to Pay: This field is completed with the amount of expenses that will be billed to the patient and are the patient’s responsibility to pay. Incurred expenses that will not be the patient’s responsibility to pay (i.e. expenses paid by TPL, discounts, write offs, etc. cannot be used to meet spend down and are not included in this field). Enter $0 if the patient will not be billed.

Total Amount Billable to State Only Funds: This field is completed with the amount of expenses that will be paid by state only funding. If state funds are intermingled with federal funds they are not entered in this field.

Please initial here…: This field is completed when the amount in "Total Daily Expense Patient is Responsible to Pay" is a good faith estimate based on third party liability and discount information available at the time the form is completed.

Name of Provider / Authorized Employee Completing Form: This field is completed with the typed full name of the provider of the services or authorized employee. The individual completing the Provider Form is attesting to the accuracy of the information and must be able to verify the amount billed to the patient, upon request.

Title: This field is completed with the title of the provider or authorized employee completing the form.

Date: This field is completed with the date the form is completed and signed.

Address: This field is completed with the address of the provider or authorized employee completing the form.

Phone: This field is completed with the phone number of the provider or authorized employee completing the form.

Signature: This field is completed with the signature or signature stamp of the provider or authorized employee completing the form.
**MO HEALTHNET ELIGIBILITY REVIEW INFORMATION**

We are required to complete an annual review of MO HealthNet eligibility. In order to determine continued eligibility, we are asking you to complete all questions on this form. Race and ethnic group information is only for statistical use and is optional. The Social Security Number is required only for persons who are receiving or applying for MO HealthNet coverage.

After you have completed the form, please sign on the line indicated “Signature/Affidavit/Mark”. Return this form to the return address above or to any local Family Support Division facility by *** ******* ***.

If employed, please include proof of your household income such as a month of your most recent paycheck stubs, letter from your employer, or copies of your latest tax return if self-employed.

Verification of resources such as bank statements, quarterly statements for retirement accounts or written statements from financial institutions is required. These documents will be returned to you at your request.

Failure to return this form may result in MO HealthNet coverage being canceled. Contact the Family Support Division Information Center at 855-373-4636 if you have any questions.

**Do you want to register to vote?** If so, just fill out the voter registration form included with the review form and return it to any local Family Support office or with this form. If you don’t fill out the form, MO HealthNet coverage will not be affected.

**Instructions:** Please read each item carefully before you answer it. The answers you give will be used to determine continued eligibility for MO HealthNet. If you need assistance in completing the form, or have any questions, please contact the Family Support Division Contact Center. You must answer each question accurately and completely in ink. You may be required to provide verification of your statements. Attach an additional sheet or use the “Additional Information” section if more space is needed for any section.

<table>
<thead>
<tr>
<th>Head of Eligibility Unit Supercase</th>
<th>DCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City</td>
</tr>
<tr>
<td>Current Phone</td>
<td>Work or Message Phone</td>
</tr>
</tbody>
</table>

**Below, list your name first, then list all other persons who live with you.**

<table>
<thead>
<tr>
<th>Name (First, Middle, Last) (Maiden)</th>
<th>Hispanic Y/N</th>
<th>Race/ Sex</th>
<th>Relationship to YOU (self)</th>
<th>Birthdate</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

*1 Caucasian 2 Black/African American 4 American Indian/Alaska Native 5 Asian 6 Native Hawaiian/Pacific Islander

**Do you or your spouse if married, reside in or plan to enter a Nursing or Residential Care Facility?**

If Yes, who: ____________________________ Where: ____________________________ When: ____________________________

I/We are residents of Missouri and intend to remain in Missouri. □ Yes □ No

Has there been any change in citizenship or immigration status for individuals currently in your household and receiving MO HealthNet? □ Yes □ No If Yes, list the individual whose status has changed with the current information in the blanks.

<table>
<thead>
<tr>
<th>Name</th>
<th>Immigration Status</th>
<th>Registration Number</th>
<th>Date of Entry</th>
</tr>
</thead>
</table>
### MO HEALTHNET ELIGIBILITY REVIEW FORM

**Is anyone in the household blind or disabled?** □ Yes □ No □ If Yes, who: __________________________

If you indicated that you are blind:
1. Do you have a sighted spouse? □ Yes □ No
2. Do you solicit alms? □ Yes □ No
3. Have you had eye surgery since the last review or application? □ Yes □ No
4. If you are under the age of 75, are you willing to have medical treatment or an operation to correct blindness? □ Yes □ No
5. If recommended, are you willing to accept vocational training or work at an occupation for which you are suited? □ Yes □ No
6. Are you living in or supported by a public, medical or private institution? □ Yes □ No

### CASH AND SECURITIES - PERSONAL PROPERTY

I/We have the following cash, securities, or personal property.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>IN WHOSE NAME</th>
<th>LOCATION</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- a. Checking account/joint checking accounts
  - Account numbers:
- b. Savings accounts, joint savings accounts
  - Account numbers:
- c. Patient accounts at a nursing home or other institution
- d. Savings or cash at home, on my person, or being held by someone else
- e. Stocks, bonds, or other investments. If yes, how many?
- f. Notes or mortgages owed to you/Promissory notes
- g. Trust funds
- h. Annuity policies
- i. Certificates of Deposit
- j. Retirement funds
- k. Property in Probate Court
- l. Property held in Safe Deposit box (State location and contents of box)

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>VALUE</th>
<th>DEBT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- m. Household furniture (in use)
- n. Household furniture (not in use)
- o. House trailer (Mobile home)
- p. Jewelry (other than wedding and engagement rings, watches or costume jewelry)
- q. Business equipment
- r. Livestock, grain, produce, farm equipment, tools, etc
- s. other (Explain)

<table>
<thead>
<tr>
<th>MAKE</th>
<th>YEAR</th>
<th>OWNER</th>
<th>LICENSED Y/N</th>
<th>VALUE</th>
<th>DEBT</th>
<th>HOW USED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- t. Vehicles (include recreational and watercraft)
Name:
Address:

Phone Number:
DCN:

MO HEALTHNET ELIGIBILITY REVIEW FORM

REAL PROPERTY

I/We own or are buying real estate.  □ Yes  □ No

LIST KIND AND LOCATION          WHO HOLDS THE MORTGAGE?          LOAN NUMBER          WHOSE NAME IS ON THE DEED?          CURRENT VALUE          AMOUNT OWED          EQUITY          HOW IS IT USED?


TRANSFER OF PROPERTY OR RESOURCES

Has anyone in your home sold or given away any money, vehicles property or other resources?  □ Yes  □ No

If yes, complete the following:

What?
When?
To Whom?
Why  __________________________  __________________________  __________________________

Amount received $ __________________________

LIFE INSURANCE

Does anyone in your home own a life insurance policy?  □ Yes  □ No

LIST PERSON INSURED          NAME OF COMPANY          POLICY NUMBER          FACE VALUE          PAID BY WHOM          DATE PURCHASED          IRREVOCABLE Y/N

HEALTH INSURANCE (other than MO HealthNet):

I/We have medical insurance.  □ Yes  □ No  If Yes, complete the following:

Name of Insured          Name of Company          Policy Number          Policy Holder          Coverage Type (Doctor or Hospital)  If limited, explain

INCOME

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

Is anyone in your household employed?  □ Yes  □ No  If Yes, complete the following and attach verification:

NAME          EMPLOYER NAME          EMPLOYER PHONE          PAY RATE          PER*          CHECK DATE          DATE RECD          GROSS INCOME          TIPS, ETC

* Hour  Day  Week  Every two weeks  Twice monthly  Month

Does anyone in your household operate his/her own business or are otherwise self-employed?  □ Yes  □ No

If Yes, who:  __________________________.  If Yes, complete below and attach verification.

Describe the type of self-employment (babysitting, farm income, other)  __________________________.

Enter amount earned  __________________________ Per * □ Hour  □ Day  □ Week  □ Every two weeks  □ Twice monthly  □ Month

Do you anticipate any changes in employers, hours worked or wages paid?  □ Yes  □ No

If Yes explain:  __________________________

Is there anyone who plans to go to work?  □ Yes  □ No  If Yes, who:

Where:  __________________________

When:  __________________________
Name:
Address:

Phone Number:

DCN:

MO HEALTHNET ELIGIBILITY REVIEW FORM

Do you or any other household member receive money from any of the following sources?

<table>
<thead>
<tr>
<th>Source</th>
<th>Yes</th>
<th>NO</th>
<th>Amount</th>
<th>Yes</th>
<th>No</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td></td>
<td></td>
<td>Union Funds or Pension Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td></td>
<td></td>
<td>Insurance Settlements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimony</td>
<td></td>
<td></td>
<td>VA Aid and Attendance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Support payments</td>
<td></td>
<td></td>
<td>Armed Forces Allotment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money from others (friends, relatives, etc)</td>
<td></td>
<td></td>
<td>Room and/or Board Received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veteran's Benefits</td>
<td></td>
<td></td>
<td>Money from Sale of Property</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worker's Compensation</td>
<td></td>
<td></td>
<td>Interest from Savings/Checking Account</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment Compensation</td>
<td></td>
<td></td>
<td>Income received from Trusts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability or Sick Benefits</td>
<td></td>
<td></td>
<td>Income received from Annuities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from Training Program</td>
<td></td>
<td></td>
<td>Rent received from Land/Buildings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any other income
Explain:

Has anyone recently applied for any of the above benefits?  □ Yes  □ No
If Yes, explain:

COLLATERAL INFORMATION

Please provide the names of two persons who live outside of your home and are not related to you, who can verify your statements.

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This person is able to verify my statements because:

<table>
<thead>
<tr>
<th>This person is able to verify my statements because:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ADDITIONAL INFORMATION: (If additional room is needed for any question please enter information here and attach verification as requested)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Page 4 of 6

FA402 (05-14)
MO HEALTHNET ELIGIBILITY REVIEW FORM

PLEASE READ CAREFULLY AND SIGN BELOW:

I, (We), further authorize the Department of Social Services, through the Director of Family Support or his appointee, to make an investigation of these circumstances and statements.

I, (We), will provide Social Security Numbers (SSN) of all persons applying for or receiving public assistance. It is a condition of eligibility except for Blind Pension. The SSN will be used to determine eligibility level of benefits, verify information, prevent duplicate participation and facilitate mass changes in Federal benefits (Section 1137 of the Social Security Act). Included in the agencies contacted for income and eligibility information are the Social Security Administration, the Internal Revenue Service, and the Missouri Division of Employment Security. Some of the information may be obtained by computer match.

I, (We), will notify the Department of Social Services promptly of any changes in income, expenses, property holdings, financial conditions, household composition, and any change in address.

This is to certify under penalty of perjury that the forgoing information is true, accurate, and complete. I, (We), understand that any false claims, statements, or documents, or concealment of any material fact, may be prosecuted under applicable laws of the State of Missouri and/or the United States.

It is a crime, and upon conviction, punishable by imprisonment by the Missouri Division of Corrections for a period not to exceed five years; or by confinement in the county jail for a period not to exceed one year; or by fine not to exceed one thousand dollars; or by both, where an act or series of acts a person defrauds the state of one hundred fifty dollars or more, or a misdemeanor if the amount is less than one hundred fifty ($150) dollars.

When the person applies to receive monetary payments, hospital, medical, dental, or pharmaceutical service or commodity provided pursuant to provisions of chapter 208 or 209 RSMo and the person shall knowingly: (a) make, or (b) cause to be made, or (c) aids or abets another in the making of any false statements or misrepresentation of any fact required to be reported either by law or by rule or regulation of this state or of the United States in applying for public assistance or any fact used in the determination of any person's initial or continued eligibility for any public assistance with the intent to secure public assistance when not entitled to public assistance or with intent to secure more public assistance benefits than the person is entitled to. The same penalties apply to any person who knowingly (a) conceals or (b) knowingly fails to report or (c) knowingly causes the concealment or failure to report or (d) knowingly aids or abets another in the concealment or failure to report any fact or event required to be reported in applying for or used in the determination of any persons initial or continued eligibility for public assistance or food stamps or to secure public assistance or food stamps in an amount greater than entitled to receive.

ATTENTION: Federal regulations require that the Missouri Department of Social Services (DSS) maintain a publicly available "Notice of Privacy Practices" that describes our policy for handling protected health information. The department has implemented a privacy policy and prepared a Notice of Privacy Practices. You may obtain a copy of this notice on the DSS Web site at http://www.dss.mo.gov/hipaa/hprivacy.pdf or from any county DSS office.

My 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.

<table>
<thead>
<tr>
<th>Signature/Affidavit/Mark</th>
<th>Date</th>
<th>Signature/Affidavit/Mark</th>
<th>Date</th>
</tr>
</thead>
</table>

Page 5 of 6
You may contact the Family Support Division by calling the FSD Information Center toll free Monday thru Friday 7am - 6pm at 1-855-373-4636 (1-855-FSD-INFO).

You may also call the Family Support Division Automated Line available 24 hours, 7 days a week at 1-800-392-1261.
APPOINTING AN AUTHORIZED REPRESENTATIVE (IM-6AR) INSTRUCTIONS

Section 1: The participant names his/her authorized representative (AR) and selects what authority the AR will have.

- Helping with MO HealthNet application;
- Helping with Food Stamp application;
- Helping with Temporary Assistance application;
- Acting ongoing for annual reviews, reporting changes, etc.;
- Or any combination of these options.

Space is provided for the participant and his/her spouse to sign appointing the AR.

Section 2: This section is specific to MO HealthNet programs, and is not needed for Temporary Assistance or Food Stamps. The participant authorizes release of Protected Health Information (PHI) and other information as necessary to establish or maintain eligibility for MO HealthNet programs.

Space is provided for the participant and his/her spouse to sign authorizing release of PHI.

**NOTE:** It is very important that the participant and his/her spouse sign this section if the AR will be receiving any notices or information from Family Support Division.

**NOTE:** This section is not necessary if the individual/organization being authorized is a medical provider, or the participant's attorney, attorney-in-fact, guardian or conservator, or court appointed public administrator.

Section 3: The AR must agree and accept the appointment as authorized representative. Part of accepting is acknowledging and understanding the AR is required to protect the privacy of the participant they represent.
Use this form if you would like an authorized representative to help you apply for MO HealthNet coverage, Temporary Assistance, Food Stamps, and/or act on your behalf if you get MO HealthNet coverage, Temporary Assistance, and/or Food Stamps.

If you are a resident of a Drug and Alcohol treatment and rehabilitation program and you want to apply for Food Stamp benefits, you must appoint an authorized representative who is employed by the treatment facility to apply and access benefits for you.

If you reside in a group home and are eligible for Food Stamp benefits on your own, you do not need to sign this form to apply for or receive Food Stamp benefits.

You can choose to have an authorized representative or you can act on your own behalf. If you already have a guardian, conservator, or attorney-in-fact appointed by a valid Power of Attorney under Missouri law, they must appoint an authorized representative for you. Even if you choose to have an authorized representative, the FSD may sometimes need to contact you directly.

Instructions:
1. Fill out and sign your name(s) in Sections 1 and 2. Only one (1) form is necessary if the same authorized representative is being appointed for both members of a married couple.
2. Have the person, facility, or organization you're appointing fill out and sign their name in Section 3 to verify they accept the responsibilities listed below.
3. Return your completed form to the FSD within 30 days of the date(s) you and your authorized representative sign and date the form.

SECTION 1: YOUR INFORMATION AND AUTHORIZATION TO BE REPRESENTED

YOUR NAME(S)                                              TELEPHONE NUMBER

ADDRESS

DATE OF BIRTH OR DCN (CASE NUMBER)

I APPOINT AS MY/OUR AUTHORIZED REPRESENTATIVE:

NAME

NOTE: By appointing an authorized representative, you are consenting to allow the FSD to send letters and notices to your authorized representative.

For MO HealthNet and Food Stamps, I/we authorize this person or organization to be responsible for (check one or more boxes):
- Helping me/us apply for MO HealthNet coverage
- Helping me/us apply for Food Stamp benefits
- Acting on my/our behalf if I/we get MO HealthNet coverage, including annual reviews, and reporting changes
- Acting on my/our behalf if I/we get Food Stamp benefits, including mid-certification reviews, and reporting changes.

For Temporary Assistance, I/we authorize this person to be responsible for (check one or more boxes):
- Helping me/us apply for Temporary Assistance benefits
- Acting on my/our behalf if I/we get Temporary Assistance benefits, including annual reviews, and reporting changes.

The person or organization I/we have appointed is of age 18 or older and knows my/our situation well enough that they can complete my/our application or act on my/our behalf. They will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation or rule of this State or the United States.

NOTE: Organizations may not be appointed for Temporary Assistance applicants or recipients.

I/we understand that I/we am responsible for the information given by my/our authorized representative, including any information that may be incorrect.

YOUR (APPLICANT/PARTICIPANT) SIGNATURE

YOUR SPouse'S SIGNATURE

DATE
SECTION 2: YOUR AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND OTHER INFORMATION (MO HEALTHNET ONLY)

Please write your name and the name of a person who can receive protected health information and other information about you. Write the name of a person, not an organization.

I/we, (your name(s))

request and authorize Family Support Division to disclose information to this person:

(REPRESENTATIVE'S NAME)

Because I'm/we're giving this request and authorization, the FSD may release to the person named above:

- Requests for information
- Eligibility notices and medical information about this application
- My/our annual review
- Letters about agency action

This authorization will continue during the final decision on my/our application, my/our annual review, or agency action for which I/we gave this authorization. If I/we want to end my authorization sooner, I/we must tell the FSD in writing before the final application, annual review, or agency action decision.

I/we understand that the FSD is not responsible for what happens to information they release because I/we have requested and authorized them to disclose my/our Protected Health Information. I/we understand and agree that the FSD has given me/us a signed copy of this form.

YOUR (APPLICANT/PARTICIPANT) SIGNATURE

DATE

YOUR SPOUSE'S SIGNATURE

SECTION 3: AUTHORIZED REPRESENTATIVE AGREEMENT AND ACCEPTANCE

Individual acting as Authorized Representative: Please fill out and sign this section.

REPRESENTATIVE'S NAME

TELEPHONE NUMBER

REPRESENTATIVE'S ADDRESS

REPRESENTATIVE'S DATE OF BIRTH (TEMPORARY ASSISTANCE AND FOOD STAMPS)

I am age 18 or older and know the applicant's situation well enough to complete their application or act on their behalf. I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation or rule of this State or the United States.

I agree to be the applicant's authorized representative for the reason and length of time stated above. I will protect the privacy of any information I get while acting as authorized representative as required by Federal, State and local laws, regulations, ordinances, and directives about privacy.

AUTHORIZED REPRESENTATIVE'S SIGNATURE

DATE
**Individual acting as authorized representative due to affiliation with an organization or facility:** Please fill out and sign this section.

**ORGANIZATION OR FACILITY NAME**

**ORGANIZATION OR FACILITY ADDRESS**

**ORGANIZATION OR FACILITY E-MAIL**

**ORGANIZATION OR FACILITY TELEPHONE**

I represent the organization or facility named above. I have provided proof of my identity to the Family Support Division. I have knowledge of the applicant's or participant's situation well enough to complete their application or act on their behalf. I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation, or rule of this State or the United States.

I will report changes to the FSD on behalf of the participant as needed. I will inform the FSD if I am no longer an authorized representative.

I understand I must do the following once I stop being an authorized representative:

- Immediately stop using the EBT card.
- Notify the FSD of the change in authorized representative status within 48 hours.

I agree to be the applicant's authorized representative. I will protect the privacy of any information I get while acting as an authorized representative as required by Federal, State, and local laws, regulations, and directives about privacy.

**AUTHORIZED REPRESENTATIVE'S SIGNATURE**

**DATE**

---

**Need Help?**

- By Phone: 1-855-FSD-INFO (1-855-373-4636)
- Online: mydss.mo.gov
- In person: Visit any FSD Office. To find an office in your area, call the number above or visit us online.
Appendix A - Disability

Directions:

Filling out these forms may speed up the application process. They do not have to be submitted with the application.

- Fill out all 4 forms if you are disabled but do not receive Social Security Disability or SSI (Supplemental Security Income):

  1. **Disability History**: Describe your disability in detail so we know what records or tests are needed (pages 3-4).

  2. **Work History**: List where you have worked over the last 10 years so we know if you have been substantially and gainfully employed (pages 5-6).

  3. **Provider History**: List the doctors, hospitals, and other providers who have treated your disability in the last 12 months so we can get your records faster (pages 7-8).

  4. **Authorization to Release Health Information**: Allow us permission to get your medical records from your doctor and other providers (pages 9-10).

Need help with your application? Call us at 1-855-373-4636. If you need help in a language other than English, tell the customer service representative the language you need. TTY users can call: 1-800-735-2966.
## Pertinent Information and Observations of FSD Staff:

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Personal Information: Age _____</td>
<td>Sex _____</td>
<td>Height _____</td>
<td>Weight _____</td>
<td></td>
</tr>
<tr>
<td>2. Highest Grade Completed: _____</td>
<td>GED</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3a. What physical symptoms/problems do you have?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3b. What mental health symptoms/problems do you have?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have crying spells or depression because of your disability?</td>
<td>Yes</td>
<td>No</td>
<td>How often?</td>
<td></td>
</tr>
<tr>
<td>3c. Are your mental health symptoms due to your current circumstances (i.e. family, job, health)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. When did these symptoms/problems begin?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. When did these symptoms first prevent you from working?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. What are the limitations of your daily activities from this disability? Please list those you are unable to perform:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to perform?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you in need of caretaking?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, who provides? (Check one)</td>
<td>Nurse</td>
<td>Relative</td>
<td>Neighbor</td>
<td>Friend</td>
</tr>
<tr>
<td>7. Did you see a doctor or seek medical treatment for your symptoms?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician ____________________________</td>
<td>How often?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment received ____________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When? ____________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician ____________________________</td>
<td>How often?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment received ____________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When? ____________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have you been given a specific diagnosis for your problem?</td>
<td>Yes</td>
<td>No</td>
<td>What is the diagnosis?</td>
<td></td>
</tr>
<tr>
<td>9. Have you gone to Vocational Rehabilitation?</td>
<td>Yes</td>
<td>No</td>
<td>(If yes, obtain VR reports and any medical examinations required by VR) What is the status of your Vocational Rehabilitation referral?</td>
<td></td>
</tr>
</tbody>
</table>
10. Have you applied for (check if applicable)? □ Social Security  □ SSI  □ VA
    Were you examined by a doctor for this application? □ Yes  □ No  (If yes, obtain medical reports from SSA)
    What is the status of your application?  

11. Did your problem require physical therapy? □ Yes □ No  (Obtain medical information or reports)
    If yes, where? When?  
    Describe therapy:  

12. Describe any pain you have from these problems. (If specialized care was received for this pain, obtain medical reports.)

13. List medications you take, prescribed or over-the-counter, side effects and how often medication is taken:

14. Who prescribed the medications? (Obtain medical information)

15. Have you been treated by or referred to a(n):  
    Orthopedist  
    Internist  
    Neurologist  
    Cardiologist  
    Psychologist/Psychiatrist  
    Other specialist  
    YES NO REFERRED TREATED

16. Have you been hospitalized due to your disability or illness? □ Yes □ No
    If yes, where?  
    How long? Dates?  
    Admitting physician name?  

Medical information must be current (within the past 12 months). It must include information on each of the claimant’s complaints. If not current or complete, schedule an examination.

ADDITIONAL INFORMATION AND COMMENTS
**Instructions:** Please list all employers within the last ten (10) years, starting with the most recent. If you had more employers, please continue on a separate sheet and attach to this form.

<table>
<thead>
<tr>
<th>EMPLOYER</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER’S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</td>
<td></td>
</tr>
<tr>
<td>DATES OF EMPLOYMENT: FROM (MONTH/YEAR)</td>
<td>TO (MONTH/YEAR)</td>
</tr>
<tr>
<td>JOB DESCRIPTION/DUTIES</td>
<td></td>
</tr>
<tr>
<td>REASON FOR LEAVING</td>
<td></td>
</tr>
<tr>
<td>WAS THIS THROUGH A SHELTERED WORKSHOP?</td>
<td>□ YES □ NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYER</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER’S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</td>
<td></td>
</tr>
<tr>
<td>DATES OF EMPLOYMENT: FROM (MONTH/YEAR)</td>
<td>TO (MONTH/YEAR)</td>
</tr>
<tr>
<td>JOB DESCRIPTION/DUTIES</td>
<td></td>
</tr>
<tr>
<td>REASON FOR LEAVING</td>
<td></td>
</tr>
<tr>
<td>WAS THIS THROUGH A SHELTERED WORKSHOP?</td>
<td>□ YES □ NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYER</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER’S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</td>
<td></td>
</tr>
<tr>
<td>DATES OF EMPLOYMENT: FROM (MONTH/YEAR)</td>
<td>TO (MONTH/YEAR)</td>
</tr>
<tr>
<td>JOB DESCRIPTION/DUTIES</td>
<td></td>
</tr>
<tr>
<td>REASON FOR LEAVING</td>
<td></td>
</tr>
<tr>
<td>WAS THIS THROUGH A SHELTERED WORKSHOP?</td>
<td>□ YES □ NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYER</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER’S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</td>
<td></td>
</tr>
<tr>
<td>DATES OF EMPLOYMENT: FROM (MONTH/YEAR)</td>
<td>TO (MONTH/YEAR)</td>
</tr>
<tr>
<td>JOB DESCRIPTION/DUTIES</td>
<td></td>
</tr>
<tr>
<td>REASON FOR LEAVING</td>
<td></td>
</tr>
<tr>
<td>WAS THIS THROUGH A SHELTERED WORKSHOP?</td>
<td>□ YES □ NO</td>
</tr>
</tbody>
</table>
**MISSOURI DEPARTMENT OF SOCIAL SERVICES**  
**FAMILY SUPPORT DIVISION**  
**HOSPITALS, MEDICAL FACILITIES AND PHYSICIANS SEEN WITHIN THE PAST YEAR**

<table>
<thead>
<tr>
<th>INDIVIDUAL NAME (FIRST, MIDDLE, LAST)</th>
<th>INDIVIDUAL DCN</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
</table>

**Instructions:** List all hospitals, medical facilities, and physicians that have provided care or services to you within the last year (12 months). If needed, use a separate sheet and attach to this form.

If you have not had any services in the last year, check here: ☐ NONE

**DO YOU HAVE A PRIMARY CARE PHYSICIAN?**

| ☐ YES | ☐ NO |

If yes, list your primary care physician here:

<table>
<thead>
<tr>
<th>FACILITY AND DOCTOR NAME(S)</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</td>
<td></td>
</tr>
<tr>
<td>REASONS(S) SEEN</td>
<td>DIAGNOSIS</td>
</tr>
<tr>
<td>LAST DATE SEEN</td>
<td>HOSPITALIZATION</td>
</tr>
<tr>
<td>☐ YES</td>
<td>☐ NO</td>
</tr>
<tr>
<td>UPCOMING APPOINTMENTS/DATES</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FACILITY AND DOCTOR NAME(S)</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</td>
<td></td>
</tr>
<tr>
<td>REASONS(S) SEEN</td>
<td>DIAGNOSIS</td>
</tr>
<tr>
<td>LAST DATE SEEN</td>
<td>HOSPITALIZATION</td>
</tr>
<tr>
<td>☐ YES</td>
<td>☐ NO</td>
</tr>
<tr>
<td>UPCOMING APPOINTMENTS/DATES</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FACILITY AND DOCTOR NAME(S)</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</td>
<td></td>
</tr>
<tr>
<td>REASONS(S) SEEN</td>
<td>DIAGNOSIS</td>
</tr>
<tr>
<td>LAST DATE SEEN</td>
<td>HOSPITALIZATION</td>
</tr>
<tr>
<td>☐ YES</td>
<td>☐ NO</td>
</tr>
<tr>
<td>UPCOMING APPOINTMENTS/DATES</td>
<td></td>
</tr>
</tbody>
</table>

MC 886-4565 (6-15) IM-61D
<table>
<thead>
<tr>
<th>FACILITY AND DOCTOR NAME(S)</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>REASONS SEEN</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LAST DATE SEEN</th>
<th>HOSPITALIZATION</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UPCOMING APPOINTMENTS/DATES</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>FACILITY AND DOCTOR NAME(S)</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>REASONS SEEN</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LAST DATE SEEN</th>
<th>HOSPITALIZATION</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UPCOMING APPOINTMENTS/DATES</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>FACILITY AND DOCTOR NAME(S)</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>REASONS SEEN</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LAST DATE SEEN</th>
<th>HOSPITALIZATION</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UPCOMING APPOINTMENTS/DATES</th>
</tr>
</thead>
</table>
STATE OF MISSOURI

AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, ____________________________________________________________, authorize and request

(NAME OF CONSUMER, PARENT, GUARDIAN, LEGAL REPRESENTATIVE)

Check all that apply:

☐ Department of Mental Health (DMH) ☐ Department of Health and Senior Services (DHSS)
☐ Department of Social Services (DSS) ☐ Department of Elementary and Secondary Education (DESE)
☐ Department of Corrections (DOC) ☐ Missouri Veterans Commission (MVC)
☐ Other ____________________________________________________

(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

To disclose/release the below specified information of:

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHO RECEIVED SERVICES FROM (DATES)

To (check all that apply)

☐ Department of Mental Health (DMH) ☐ Department of Health and Senior Services (DHSS)
☐ Department of Social Services (DSS) ☐ Department of Elementary and Secondary Education (DESE)
☐ Department of Corrections (DOC) ☐ Missouri Veterans Commission (MVC)
☐ Other ____________________________________________________

(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

☐ Eligibility Determination ☐ Assessment ☐ Aftercare
☐ Placement ☐ Transfer/Treatment ☐ Treatment Planning
☐ Continuity of Services/Care ☐ Conditional/Unconditional Release Hearing ☐ At Consumer’s Request

☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, DOC, MVC, etc.) to obtain services consistent with the ____________________________ program (please complete the name of the program in which you want to participate)

☐ Other (specify) ____________________________

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

☐ Discharge Summary ☐ Progress Notes ☐ Treatment Plan and/or Review
☐ Social Service Assessment ☐ Educational testing, IEP, transcript, and/or grading reports
☐ Medical/Psychiatric Assessment(s) ☐ Psychotherapy Notes
☐ Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.

☐ Other ____________________________
1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases or environmental conditions, and/or alcohol/drug abuse.

2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.

4. This authorization becomes effective on __________________________. This authorization automatically expires on the following date, event or special condition _________________.

5. If I fail to specify an expiration date, this authorization will expire in one year.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so IN WRITING and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will NOT be affected.

7. I understand that I have the right to receive a copy of this authorization. A photographic copy of this authorization is as valid as the original.

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

**THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS:** Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

**SIGNATURE OF CONSUMER**

**DATE**

**WITNESS**

**DATE**

**SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE**

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

**NOTICE OF REVOCATION**

**DATE**

I, ____________________________ , (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

**SIGNATURE OF CONSUMER**

**DATE**

**WITNESS**

**DATE**

**SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE**

**DATE**

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.
I _________________ do hereby authorize and request that the State of Missouri, Department of Social Services, Family Support Division, release or disclose to the following organization or person: ____________________________ (person/organization name) at ____________________________ (address), ____________________________ (telephone number), the financial and health information of the person listed below:

NAME ON INFORMATION TO BE DISCLOSED

BIRTH DATE

SOCIAL SECURITY NUMBER OR DGN

THE SPECIFIC INFORMATION TO BE DISCLOSED IS ALL FINANCIAL AND MEDICAL INFORMATION OF THE ABOVE NAMED INDIVIDUAL, INCLUDING, BUT NOT LIMITED TO, DOCUMENTS AND INFORMATION NECESSARY TO COMPLETE THE FOLLOWING PURPOSES.

THE PURPOSE OF THIS REQUEST IS TO:

☐ ASSIST WITH APPLICATION FOR MO HEALTHNET BENEFITS
☐ ASSIST WITH RENEWAL OF ELIGIBILITY FOR MO HEALTHNET BENEFITS
☐ ASSIST WITH POSSIBLE CHANGES IN ELIGIBILITY FOR MO HEALTHNET BENEFITS

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

You cannot be required to sign this disclosure authorization form. Your MO HealthNet application will not be denied if you do not sign this form. If you do not sign this form, your benefits could be delayed because necessary information may not be promptly provided to Family Support Division. If you do sign this form, you must be given a copy. You have the right to inspect the information to be disclosed and you may revoke this authorization at any time by writing the facility named above and the DSS Privacy Officer at PO Box 1527, Jefferson City, MO 65102. A revocation of this authorization will not reverse disclosures of information already made under the authorization. You understand that once information is released to the above named facility or individual specified above, your information may be subject to re-disclosure. Alcohol and drug abuse treatment records are specifically protected by federal regulations (42 CFR Part 2) and by signing this authorization, without restriction, you are allowing the release of all medical records including any alcohol and/or drug records that may be in your files to the above named facility or individual specified above. If you do not want your alcohol and/or drug records released, initial in the following box.

SIGNATURE

I have had an opportunity to review and understand the content of this authorization form, and by signing this authorization, I confirm it accurately reflects my wishes. **Note: If a guardian, legal representative or a personal representative signs this document; they must provide separate documentation of their status and authority to sign this authorization to the Family Support Division along with the signed authorization.**

SIGNED (INDIVIDUAL, GUARDIAN, LEGAL OR PERSONAL REPRESENTATIVE) ____________________________ DATE ____________

ADDRESS

EXPIRATION DATE – This authorization is good until ____________________________ or one year from signature if no date entered.

PLEASE RETURN REQUESTED INFORMATION TO FOLLOWING HCBS PROVIDER OR NURSING HOME UNIT:

OFFICE ____________________________ TELEPHONE NUMBER ____________________________

ADDRESS ____________________________

PLEASE PROVIDE AN E-MAIL ADDRESS ____________________________
Missouri Medigap Shopping Guide

Medigap (Medicare Supplement) insurance plans
Medigap rate information
Part D drug plans
Missouri Rx program
Medicare Advantage plans
Medicare questions?
Get answers for free

Call 800-390-3330
or
Visit missouriclaim.org

This free nonprofit Medicare counseling program will answer questions about:

- Medigap insurance (Medicare Supplement)
- Enrollment and billing
- Medicare prescription drug plans
- Long-term care planning and insurance
- Medicare Advantage plans
- Appeals and grievances
- Limited income assistance programs
- Suspected waste, fraud and abuse

Trained volunteers throughout Missouri will help answer your questions.

CLAIM is sponsored by the federal Administration for Community Living (ACL) and the Department of Insurance, Financial Institutions and Professional Registration (DIFP)
At the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP), we work to provide complete information about insurance to people on Medicare.

As you have learned, becoming Medicare eligible does not mean all of your health care needs expenses are covered. Medigap insurance, also called Medicare Supplement, can be an important part of your overall health insurance plan. It is available to Missourians who are at least 65 years old or disabled.

Medigap is sold by private insurance companies, and the prices those companies charge are listed in our supplemental Medigap Rate Guide.

This book also walks you through the different parts of Medicare and assistance that’s available for those who need help paying for medication.

Along with this guide, the DIFP funds a statewide volunteer program to help Medicare consumers with these tough decisions. I urge you to contact the CLAIM program for help answering your Medicare questions. More information about the program and its contact number can be found on the previous page.

Medicare can be complicated and at times confusing, but with good resources like this booklet and the CLAIM program, you can sort through the options and make decisions that best meet your health care needs.

DIFP’s Insurance Consumer Hotline
If you have questions about your insurance policy or want to file a complaint against an insurer, contact us:

800-726-7390 or difp.mo.gov
# Medigap insurance topics

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>About Medigap insurance</td>
<td>5</td>
</tr>
<tr>
<td>How to use this guide</td>
<td></td>
</tr>
<tr>
<td>Contact CLAIM for free answers</td>
<td></td>
</tr>
<tr>
<td>Medicare basics</td>
<td>6</td>
</tr>
<tr>
<td>Are you eligible?</td>
<td></td>
</tr>
<tr>
<td>Parts of Medicare</td>
<td></td>
</tr>
<tr>
<td>Medigap plans</td>
<td>7</td>
</tr>
<tr>
<td>Plans no longer sold, new plans, basic benefits, plans D and G</td>
<td></td>
</tr>
<tr>
<td>Medigap enrollment information</td>
<td>8</td>
</tr>
<tr>
<td>Enrolling for the first time</td>
<td></td>
</tr>
<tr>
<td>Renewing</td>
<td></td>
</tr>
<tr>
<td>Changing to a new company</td>
<td></td>
</tr>
<tr>
<td>Premium information</td>
<td></td>
</tr>
<tr>
<td>Special rates for disabled Missourians</td>
<td>9</td>
</tr>
<tr>
<td>“Select” plans</td>
<td></td>
</tr>
<tr>
<td>Where you live could affect insurance rates</td>
<td></td>
</tr>
<tr>
<td>Guaranteed issue rights for Medigap policies</td>
<td>10</td>
</tr>
<tr>
<td>Situations where your insurance company cannot deny you a Medigap policy</td>
<td></td>
</tr>
<tr>
<td>Medigap plan shopping tips</td>
<td>12</td>
</tr>
<tr>
<td>Shop for benefits and price</td>
<td></td>
</tr>
<tr>
<td>Research insurance company</td>
<td></td>
</tr>
<tr>
<td>Do’s and Don’ts of buying Medigap</td>
<td></td>
</tr>
<tr>
<td>Medigap plan options</td>
<td>14</td>
</tr>
<tr>
<td>Medigap policy options</td>
<td></td>
</tr>
<tr>
<td>Medigap policy benefits are explained</td>
<td></td>
</tr>
<tr>
<td>Questions to ask when buying a Medigap plan</td>
<td>16</td>
</tr>
<tr>
<td>Make shopping easier with this easy-to-use worksheet.</td>
<td></td>
</tr>
<tr>
<td>Know who pays first if you have other health insurance or coverage</td>
<td>17</td>
</tr>
<tr>
<td>Medicare Part D prescription drug plans</td>
<td>19</td>
</tr>
<tr>
<td>Enrollment</td>
<td></td>
</tr>
<tr>
<td>Drug coverage gap (doughnut hole)</td>
<td></td>
</tr>
<tr>
<td>Changes in Medicare Part D</td>
<td>20</td>
</tr>
</tbody>
</table>
Compare Medigap rates

1. Use supplemental rate guide

**Compare prices using Medigap insurance rate charts**
Rate guide lists statewide average rates of the 11 available Medigap plans. Also listed: Consumer complaint history for Medigap insurers.

2. Use online tool to view current Medigap rates

Click on “Medigap (Medicare Supplement) insurance” to view the searchable rates.
Insurance Consumer Hotline: 800-726-7390
Missouri TTY user: 800-735-2966 or 711 for Relay Missouri
Web: insurance.mo.gov

Address: Consumer Affairs Division
Truman State Office Building, Room 830
PO Box 690
Jefferson City, MO 65102

Hours: 8 a.m. to 5 p.m. weekdays

Other resources

CLAIM HELP LINE (State Health Insurance Assistance Program)
Phone: 800-390-3330
Web: missouriclaim.org

MEDICARE
Phone: 800-MEDICARE (800-633-4227)
Web: medicare.gov

U.S. SOCIAL SECURITY ADMINISTRATION
Phone: 800-772-1213
Web: socialsecurity.gov

MISSOURI Rx Plan (state pharmacy assistance program)
Phone: 800-375-1406
Web: morx.mo.gov

MISSOURI VETERANS COMMISSION
Phone: 866-838-4636 or 573-751-3779
Web: mvc.dps.mo.gov

TRICARE
Phone: 888-874-9378
Web: tricare.mil

RAILROAD RETIREMENT BOARD (eligibility and enrollment)
Phone: 877-772-5772
Web: www.rrb.gov
About Medigap insurance

Also known as Medicare Supplement insurance, consumers can buy a Medigap policy to cover deductibles required under their traditional Medicare benefits. The companies selling Medigap insurance in Missouri can offer up to 11 plans.

How to use this guide

The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) regulates the insurance companies that offer Medigap policies in Missouri.

The Missouri Medigap Shopping Guide explains the basics of Medigap policies and the 11 plans offered in Missouri. It also lists the companies authorized to sell these policies in the state. The statewide, average annual premium charged for each plan can be found in the accompanying Medigap Rate Guide. Charges can vary for a number of reasons including age at time of application, where you live and what company you will be using.

Another publication you may find helpful is Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare. Written by Medicare and the National Association of Insurance Commissioners, it has excellent information about Medicare as well as health insurance. Any agent or company that offers to sell you Medigap insurance must give you a copy of the guide.

The guide can be found at medicare.gov/Publications/Pubs/pdf/02110.pdf.

Contact CLAIM for free answers

For any questions about Medicare, you can contact CLAIM, a free, nonprofit service that counsels Missourians with Medicare and their caregivers.

Trained volunteers throughout Missouri will help answer your questions.

Call: 800-390-3330
Visit: missouricclaim.org

This free Medicare counseling program will answer questions about:

- Medigap insurance
- Enrollment and billing
- Medicare prescription drug plans
- Long-term care planning and insurance
- Medicare Advantage plans
- Appeals and grievances
- Limited income assistance programs
- Suspected waste, fraud and abuse

CLAIM services are funded by the Federal Centers for Medicare and Medicaid Services and the DIFP.
Medicare basics

Medicare is a federal program that provides health insurance for those 65 and older, and some people under 65 with certain disabilities. It is the largest health insurance program in the U.S.

Medicare was signed into law by President Lyndon Johnson on July 30, 1965, in Independence, Mo. The first person enrolled in the program was former President Harry S. Truman, who was from Missouri.

Am I eligible?
Most people can join Medicare when they turn 65. You also can join if you:
- Receive Social Security disability checks for 24 months, or
- Have permanent kidney failure, known as end-stage renal disease (ESRD), or
- Have Lou Gehrig’s Disease, known as Amyotrophic Lateral Sclerosis (ALS)

PARTS OF MEDICARE

Medicare Part A (hospital insurance): No monthly premium with exceptions

- Helps pay for inpatient care in hospitals.
- Helps cover home health, hospice and skilled nursing facility care (but not long-term care).

A deductible and copays may apply.

Medicare Part B (medical insurance): Monthly premium with right to delay enrollment

- Helps pay for medical care not covered by Part A, such as doctor visits, outpatient hospital services and medical equipment.
- Helps cover some preventive services to maintain health.

The monthly premium is usually withheld from your monthly Social Security check. A deductible and coinsurance may apply.

Medigap insurance: Optional coverage with monthly premium

Also called Medicare Supplement insurance, these plans are offered by private insurance companies. Generally anyone with Parts A & B is eligible. These plans are assigned letters A-N. This is not to be confused with “parts” of Medicare, such as Parts A & B. Most of these plans cover the deductibles and/or coinsurance required in Parts A & B.

Medicare Advantage plans (like an HMO or PPO): Optional coverage with monthly premium

Also called Medicare Part C, these plans are offered by private insurers that contract with Medicare to provide your benefits. You must have Parts A & B to qualify. The company handles all aspects of a beneficiary’s health care – from enrollment to payment of providers. You cannot buy a Medigap and a Medicare Advantage policy. Deductibles, copays and coinsurance can apply.

Medicare Part D: Optional coverage with monthly premium

Helps pay for medicine through a plan offered by a private insurer approved by Medicare. You normally will pay some money when you pick up your medicine. You must have Medicare Part A and/or Part B.
Medigap plans

Several changes were made to Medigap plans in 2010. These policies give you choices in health care coverage to fill gaps in payment of deductibles, copayments and coinsurance that Original Medicare does not pay. There are 11 plans from which to choose. (Plans E, H, I, J and high-deductible J are no longer being offered to new clients, which means future rate increases may be very high since there will be fewer policyholders in the plans.)

Lower premium plans M and N

Plans M and N are designed to give you a lower premium:

- **Plan M** covers 50 percent of the Part A deductible but none of Part B deductible.
- **Plan N** includes full coverage of the Part A deductible but no coverage for the Part B deductible.
- Coverage for Part B coinsurance (as part of basic benefits) is subject to a new copay structure. The copay obligation is up to $20 for office visits and up to $50 for emergency room visits.

Basic benefits

**Hospice Part A coinsurance** (outpatient prescription drug and inpatient respite care coinsurance) is now covered as a basic benefit. You will not have to pay:

- Copay of $5 or less for outpatient prescription drug plans for pain and symptom management.
- 5 percent of the Medicare-approved amount for inpatient respite care (not including room and board).
- Plan K will cover 50 percent, and Plan L will cover 75 percent of these costs.

**Part B coinsurance:** Plans K, L and N now require you to pay a portion of Part B coinsurance and copayments, which may result in lower premiums for these plans. All other Medigap policies pay Part B coinsurance or copayments at 100 percent.

Open enrollment for new policies

If you have a Medigap policy but would like to switch companies, you have an annual guaranteed open enrollment period. See page 8 for more information.

Plans D and G

Plans D and G bought on or after June 1, 2010, have different benefits than the D or G plans bought earlier. If you bought Plan D or G before June 1, 2010, you can keep that plan and the benefits won’t change. For plans bought later:

- At-home recovery benefit has been eliminated from plans D and G.
- Part B excess charge benefit in Plan G increases from 80 percent to 100 percent.
Medigap enrollment information

Enrolling for the first time
To be eligible for Medigap coverage, you generally must be enrolled in Medicare Parts A and B. You have a six-month open enrollment period from the date when your Part B takes effect. This applies to those who are disabled as well as those 65 or older.

During open enrollment, an insurance company cannot refuse to sell you any Medigap policy it carries.

The insurer may impose up to a six-month waiting period before paying for any treatment related to a pre-existing condition.

You must be given credit for prior creditable coverage to offset any six-month waiting period.

Renewing
Each year, you have the right to renew your current plan. While your rates may increase, your insurance company cannot refuse to renew your coverage or impose any waiting period based on pre-existing conditions, as long as you stay in the same plan as before.

Changing to a new company
You have the right to switch insurance companies each year during the 30 days before or after your policy’s anniversary date (the date on which your policy first started). For example, if your policy expires June 30, you can switch policies between June 1 and July 30. You can call the insurance company to get your anniversary date.

If you change to the same-lettered plan – for example, from Plan F at Insurer XYZ to Plan F at Insurer ABC, the new insurer cannot deny you coverage and cannot impose a waiting period based on pre-existing conditions.

To demonstrate that you qualify to change insurers, you are required to show only minimal proof. Simply produce a renewal notice (from your old insurer), invoice, the old policy or other confirmation of policy ownership to the agent or new company.

If you are told that you don’t qualify, immediately call the Insurance Consumer Hotline at 800-726-7390.

If you change to a plan with fewer benefits, such as from Plan F to Plan C, you may or may not be subject to underwriting when an insurance company considers your health. Not all insurers allow you to change to a plan with fewer benefits.

If you elect to go with a more extensive plan (later in the alphabet, such as from Plan C to Plan F) you will likely be subject to underwriting, and may be denied coverage or the insurance company may impose a waiting period, based on a pre-existing condition, for any new benefits under your new plan.

Once you receive the new policy and you are certain it meets your needs, you should cancel the old policy.

Note: If you switch to a Medicare Advantage plan, you will lose the benefits of your Medigap policy.

Make sure your new policy has taken effect before your old policy is canceled.
**Premium information**

- Most companies will allow you to pay premiums monthly.
- If you pay annual premiums, a new law signed by Gov. Nixon requires insurers to refund your premium if you cancel coverage before the end of the policy year. For example, if you pay your annual premium and cancel six months later, you’ll get a refund for six months of premiums.
- Premiums for all policies likely will increase each year to account for changes in Medicare benefits or increasing medical costs. If your insurer raises your premiums, it must do so for all policyholders of your rating class for the company.

**Special rates for disabled Missourians**

Everyone under age 65, who has been approved for Social Security disability, also has the guaranteed right to buy Medigap insurance when they enroll in Part B.

The cost may differ from policies available to seniors. Pricing information for disabled Missourians under age 65 is in the accompanying Medigap Rate Guide.

When disabled Medigap policyholders turn 65, they have a second open enrollment period, and can exercise the rights of any 65-year-old becoming eligible for Medicare for the first time. They may pick the plan of their choice from any insurer and pay the same rates as other Medicare beneficiaries.

**“Select” plans**

A few Medigap policies are called “select” plans. Similar to an HMO, they require you to go to specific health care providers for covered services, but the benefits offered under select plans A-N are the same as those in regular Medigap plans.

The rates for these plans are usually lower than regular Medigap policies. Select plans are not available in all parts of Missouri.

**Where you live could affect insurance rates**

Premium rates in the rate guide are based on statewide, average yearly rates.

- **Actual rate:** Your rate may vary based on factors such as where you live, your gender, whether you smoke and whether the policy is for an individual or a group.
- **Individual insurance:** An individual Medigap policy is a direct contract between you and the insurer. It provides the maximum number of consumer protections. These policies are either “guaranteed renewable” or “non-cancelable.”
- **Group insurance:** Group Medigap insurance is a contract between the insurer and a group master-policyholder such as AARP or an employer. You receive a certificate rather than a policy. The group negotiates the terms of the insurance and has the option to terminate the policy or change insurance carriers. Some insurance policies will require you to join a group or association.
### Guaranteed issue rights for Medigap policies

In all eight situations below, your insurance company cannot:
- Deny you the Medigap (Medicare Supplement) policy.
- Place conditions on the Medigap policy, such as waiting periods.
- Apply a pre-existing condition exclusion.
- Discriminate in the price of the Medigap policy based on your health status.

<table>
<thead>
<tr>
<th>You have a Medigap guaranteed issue right if ...</th>
<th>You have the right to buy ...</th>
<th>You can/must apply for a Medigap policy ...</th>
</tr>
</thead>
</table>
| **1** You have a Medicare Advantage plan and:  | Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company. You only have this right if you switch to Original Medicare rather than joining another Medicare Advantage plan. | No later than 63 days after the latest of these dates:  
  - Date coverage ends.  
  - Date on notice telling you coverage is ending (if you get one).  
  - Date on a claim denial, if this is only way you were informed. |
|   - Your plan is leaving Medicare; or  
   - Stops giving care in your area; or  
   - You move out of plan’s service area. | (DAYS ARE CALENDAR DAYS)  
As early as 60 days before your health care coverage ends but no later than 63 days after it ends. Medigap coverage can’t begin until your Medicare Advantage plan coverage has ended. | |
| **2** You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage. The employer group or you are terminating coverage. | Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company. If you have COBRA coverage, you can either immediately buy a Medigap policy or wait until COBRA coverage ends. | |
| **3** You have Original Medicare and a Medicare Select policy. You move out of the Medicare Select policy’s service area.  
You can keep your Medigap policy, however the hospitals in your new area may not be a network provider, or you may want to switch to another Medigap policy. | Medigap policy A, B, C, F, K or L sold by any insurance company in the state to which you are moving. | As early as 60 days before your health care coverage ends but no later than 63 days after it ends. |
<table>
<thead>
<tr>
<th>You have a Medigap guaranteed issue right if ...</th>
<th>You have the right to buy ...</th>
<th>You can/must apply for a Medigap policy ...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4</strong> <em>(Trial right)</em> You joined a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) when first eligible for Medicare Part A at age 65, and within the first year of joining, you decide to switch to Original Medicare.</td>
<td>Any Medigap policy sold in Missouri by any insurance company.</td>
<td>As early as 60 days before your health care coverage ends but no later than 63 days after it ends. <strong>Note:</strong> Your rights may last for an extra 12 months under certain circumstances. Also, Medigap coverage can’t begin until your Advantage plan coverage has ended.</td>
</tr>
<tr>
<td><strong>5</strong> <em>(Trial right)</em> You dropped a Medigap policy to join a Medicare Advantage plan or switch to a Medicare Select policy for the first time; you have been in the plan for less than a year and want to switch back.</td>
<td>The Medigap policy you had before you obtained the Advantage plan or Select policy, if the same company you had before still sells it. (Drug coverage won’t be included.) If it isn’t available, you can buy Medigap policy A, B, C, F, K or L sold in Missouri by any insurer.</td>
<td>As early as 60 days before your health care coverage ends but no later than 63 days after it ends. <strong>Note:</strong> Your rights may last for an extra 12 months under certain circumstances.</td>
</tr>
<tr>
<td><strong>6</strong> Your Medigap policy ends through no fault of your own, such as bankruptcy by your insurance company.</td>
<td>Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company.</td>
<td>No later than 63 days after coverage ends.</td>
</tr>
<tr>
<td><strong>7</strong> You leave a Medicare Advantage plan or drop a Medigap policy because your company hasn’t followed the rules or misled you.</td>
<td>Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company.</td>
<td>No later than 63 days after coverage ends.</td>
</tr>
<tr>
<td><strong>8</strong> You can change your Medigap policy to another insurance company 30 days before or 30 days after your policy’s annual anniversary date.</td>
<td>The Medigap policy you had before switching. If it isn’t available, you can buy a Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company. This also applies to persons switching from a discontinued plan.</td>
<td>As early as 30 days before the anniversary date of your policy and no later than 30 days after the anniversary date.</td>
</tr>
</tbody>
</table>
Medigap plan shopping tips

Shop for benefits and price
Check the benefits in each of the 11 plans. Every company must use the same letters (A through N) to label its policies. **Plan A is always a company’s lowest-priced Medigap policy.** It contains basic benefits and must be sold by every company.

Plans B through N add other benefits to fill different gaps in your Medicare coverage. Options K and L provide a product for those who can afford a higher deductible and are healthy.

Few companies sell all policies. The charts in the Medigap Rate Guide show the statewide average premiums for companies’ plans.

Research insurance company
Besides rates, consider a company’s complaint index (see Medigap Rate Guide). This numerical score helps you understand how many consumer complaints an insurer receives, compared to other companies its size.

A complaint index of 100 is average. Below 100 means the company gets fewer complaints than average, and a score above 100 means the insurer gets more complaints than average.

This information also is available by calling DIFP’s Insurance Consumer Hotline at 800-726-7390 and by visiting insurance.mo.gov.

Do’s and don’ts of buying Medigap

**What to do**
- Ask questions of friends and family.
- Know what you are buying. Insist on getting a simple outline of coverage.
- Choose the benefits you want and need. Benefits are standardized in Medigap policies. For example, the Plan C policy has exactly the same benefits with any company.
- Compare benefits for different policies before buying. Consider family and medical history.
- Check a company’s consumer complaint history with DIFP at 800-726-7390.
- Keep proof of prior creditable coverage.
- Keep the agent’s name and information for later reference.

**What not to do**
- Don’t feel pressured to buy now. You have a six-month open enrollment period.
- Don’t drop a current insurance policy until you have your new coverage.
- Don’t buy more than one Medigap policy.
- Never pay cash. Always use a check made out to the insurance company, not the agent.
- Don’t buy from agents who claim to be from the government. The government does not sell insurance.
- Don’t buy a Medigap policy if you have a Medicare Advantage plan. They won’t work together.
Plan Availability changes due to MACRA (Medicare Access and CHIP Reauthorization Act) of 2015

As a result of the passage of the federal law, MACRA in 2015, Medicare eligibles will see changes to plan offerings as of January 1, 2020. While the benefits under the current Medicare Supplement plans do not change, PLAN AVAILABILITY does change.

While the year 2020 may seem a ways off, miscommunication about the impact of MACRA is already stirring. So, please read the following carefully so you know your options and rights.

Only those Medicare eligible on or after January 1, 2020 are impacted by the changes to plan availability. Those Medicare eligible prior to January 1, 2020 are not impacted and can keep their current plans. MACRA prohibits coverage of the Part B deductible under Medicare Supplement plans as of 1/1/2020.

Impacts of MACRA on those eligible for Medicare PRIOR to January 1, 2020:

- All Medicare Supplement plan options are available to you.
- If you are enrolled in Plans C and F, you can keep your plan. These plans remain available to you.
- Can purchase the new Plan G High Deductible Plan in 2020.

Impact of MACRA on those eligible for Medicare ON or AFTER January 1, 2020:

- Cannot buy Plans C and F;
- Creates a new Plan G High Deductible;
- Re-designates the guaranteed issued plans from Plans C and F to Plans D and G;
- Makes Plan G High Deductible available to all eligible for Medicare.
### Medigap insurance plan options

<table>
<thead>
<tr>
<th>PLANS</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>F</th>
<th>F high deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic benefits</td>
<td>Basic benefits</td>
<td>Basic benefits</td>
<td>Basic benefits</td>
<td>Basic benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part A deductible</td>
<td>Part A deductible</td>
<td>Part A deductible</td>
<td>Part A deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing coinsurance</td>
<td>Skilled nursing coinsurance</td>
<td>Skilled nursing coinsurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B deductible</td>
<td></td>
<td></td>
<td>Part B deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B excess (100%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign travel emergency</td>
<td>Foreign travel emergency</td>
<td>Foreign travel emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This option has the same benefits as Plan F but a high deductible first must be paid. The trade-off is a lower monthly premium. The beneficiary pays the plan’s deductible each year before the supplemental policy pays for any services. This deductible amount is subject to increase each year.

### Explanation of Medigap plan benefits

**Basic benefits**  
(Plans A-N)

- Coverage for coinsurance for day 61-90 of inpatient hospitalization.
- Coverage for coinsurance for lifetime reserve days 91-150.
- Coverage for an additional 365 days of inpatient hospital care in your lifetime.
- Coverage for first three pints of blood.
- Coverage for 20% coinsurance for Part B services.
- Coverage for the hospice 5% coinsurance for Medicare-approved charges for inpatient respite care and 5% coinsurance for prescription pain medications.

**Part A deductible**  
(Plans B, C, D, F, G, N)  
(Partial coverage on K, L, M)

- Coverage for inpatient hospital deductible for each benefit period.
- Partial coverage on Plans K, L and M.
**Medigap insurance plan options** continued

<table>
<thead>
<tr>
<th>G</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic benefits</strong></td>
<td>Hospitalization, preventive care paid at 100%; other basic benefits paid at 50%</td>
<td>Hospitalization, preventive care paid at 100%; other basic benefits paid at 75%</td>
<td>Basic benefits</td>
<td>Basic benefits, except up to $20 copay for office visit &amp; up to $50 copay for ER</td>
</tr>
<tr>
<td><strong>Part A deductible</strong></td>
<td>50% of Part A deductible</td>
<td>75% of Part A deductible</td>
<td>50% of Part A deductible</td>
<td>Part A deductible</td>
</tr>
<tr>
<td><strong>Skilled nursing coinsurance</strong></td>
<td>50% of skilled nursing coinsurance</td>
<td>75% of skilled nursing coinsurance</td>
<td>Skilled nursing coinsurance</td>
<td>Skilled nursing coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part B excess</strong> (100%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Foreign travel emergency</strong></td>
<td></td>
<td>Foreign travel emergency</td>
<td>Foreign travel emergency</td>
<td></td>
</tr>
<tr>
<td><strong>Part B deductible</strong> (Plans C, F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part B excess</strong> (Plans F, G)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Foreign travel emergency</strong> (Plans C, D, F, G, M, N)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explanation** continued

**Skilled nursing coinsurance** (Plans C, D, F, G, M, N) (Partial coverage on K, L)
- Coverage for skilled nursing coinsurance for days 21-100 for each benefit period.
- Partial coverage on Plans K & L.

**Part B deductible** (Plans C, F)
- Coverage for the yearly deductible.

**Part B excess** (Plans F, G)
- Coverage for Part B charges over approved amount.
- Plan F pays for 100% of excess charge.
- Plan G pays for 100% of excess charge.

**Foreign travel emergency** (Plans C, D, F, G, M, N)
- Coverage for emergency care for first 60 days of a trip outside the U.S.
- Beneficiary pays for $250 deductible and 20% of cost up to $50,000.
Buying a Medigap plan worksheet

When you call an insurance company about a Medigap policy, here are some questions you might want to ask. Write down the responses for later reference.

<table>
<thead>
<tr>
<th>DATE</th>
<th>PHONE NUMBER</th>
<th>PLAN LETTER</th>
<th>COMPANY NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMPANY REPRESENTATIVE’S NAME and TITLE

How much is the monthly premium for plan?

How long has the company been selling Medigap policies?

When did the plan’s rate last increase? How many increases in last three years?

When do you expect to have another rate increase?

How many complaints has your company received in the last 12 months?

What is the most common complaint your company receives?

Why should I buy a policy from this company?

How long does it take for your company to pay a claim?

What is A.M. Best’s financial rating of your company? (They range from A++ to F)

Is this plan underwritten? (See page 22 for definition.)

Is this a group plan and, if so, how do I join the group?
Know who pays first if you have other health insurance or coverage

If you have Medicare and other health insurance coverage, each type of coverage is called a “payer.” When there is more than one payer, there are “coordination of benefits” rules that decide which one pays first. The primary payer pays what it owes on your bills, and then sends them to the second payer. There may be a third payer.

Whether Medicare pays first depends on several factors, including those listed in the chart. This chart does not cover every situation. Make sure to tell your doctor and other health care providers if you have coverage besides Medicare. This will help them send your bills to the correct payer to avoid delays.

<table>
<thead>
<tr>
<th>If you ...</th>
<th>And you are ...</th>
<th>Who pays first?</th>
<th>Who pays second?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are 65 or older, working and covered by group health plan; or covered by group health plan of a working spouse of any age</td>
<td>Enrolled in Medicare and your employer has 20 or more employees</td>
<td>Group health plan</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>Enrolled in Medicare and your employer has fewer than 20 employees, or is part of multi-employer plan where one employer has 20 or more employees</td>
<td>Medicare</td>
<td>Group health plan</td>
</tr>
<tr>
<td>Have an employer group health plan after you retire and are 65 or older</td>
<td>Enrolled in Medicare</td>
<td>Enroll in Medicare as soon as you can. Your group health plan may stop covering expenses once you are eligible for Medicare.</td>
<td>Medicare</td>
</tr>
<tr>
<td>Are disabled and covered by a large group health plan from work, or by a family member who is working</td>
<td>Enrolled in Medicare and your employer has 100 or more employees</td>
<td>Large group health plan</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>Enrolled in Medicare and your employer has fewer than 100 employees and isn’t part of a multi-employer plan where any employer has 100 or more employees</td>
<td>Medicare</td>
<td>Group health plan</td>
</tr>
<tr>
<td>Are 65 or older or disabled and covered by Medicare and COBRA</td>
<td>Enrolled in Medicare</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
</tbody>
</table>
Know who pays first  

<table>
<thead>
<tr>
<th>If you ...</th>
<th>And you are ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have end-stage renal disease (permanent kidney failure) and group health plan coverage – including retirement plan</td>
<td>In your first 30 months of Medicare eligibility or enrollment</td>
</tr>
<tr>
<td></td>
<td>Group health plan</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>Past your first 30 months of Medicare eligibility or enrollment</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>Group health plan</td>
</tr>
<tr>
<td></td>
<td>Past your first 30 months of Medicare eligibility or enrollment</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
</tr>
<tr>
<td>Have end-stage renal disease (permanent kidney failure) and COBRA coverage</td>
<td>In your first 30 months of Medicare eligibility or enrollment</td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>Past your first 30 months of Medicare eligibility or enrollment</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>COBRA</td>
</tr>
<tr>
<td>Have been in an accident where no-fault or liability insurance is involved</td>
<td>Enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td>No-fault or liability insurance, for services related to accident claim</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td>Are covered under workers’ compensation because of job-related illness or injury</td>
<td>Enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td>Workers’ compensation for claim-related services</td>
</tr>
<tr>
<td></td>
<td>Medicare will not pay in most cases</td>
</tr>
<tr>
<td></td>
<td>Medicare for non-VA-authorized services</td>
</tr>
<tr>
<td>Have veteran’s benefits</td>
<td>Enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td>VA, for VA-authorized services</td>
</tr>
<tr>
<td></td>
<td>Medicare may pay second at any non-VA facility</td>
</tr>
<tr>
<td></td>
<td>Medicare, for non-VA-authorized services</td>
</tr>
<tr>
<td>Are enrolled in TRICARE</td>
<td>Enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td>Medicare, for Medicare-covered services</td>
</tr>
<tr>
<td></td>
<td>TRICARE</td>
</tr>
<tr>
<td></td>
<td>TRICARE, for services from military hospital or other federal provider</td>
</tr>
<tr>
<td>Are enrolled in Federal Black Lung Program</td>
<td>Enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td>Federal Black Lung Program, for services related to black lung</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
</tr>
</tbody>
</table>
Medicare Part D prescription drug plans

Medicare offers prescription drug plans (PDPs) for everyone with Medicare. This coverage is called “Part D.” Like Medicare Advantage and Medigap insurance, Medicare Part D plans are sold by private insurance companies with the approval of Medicare.

Each plan may vary in cost and drugs covered. Each plan requires a monthly premium, and some plans require a deductible and copays.

Drug coverage gap (doughnut hole)

Plans have a coverage gap, or “doughnut hole.” A coverage gap means that after you and your plan have spent a certain amount of money for covered drugs, you have to pay out-of-pocket all costs for your drugs while you are in the gap.

This amount doesn’t include your plan’s monthly premium that you must continue to pay while you are in the coverage gap. Once you’ve reached your plan’s out-of-pocket limit, you will have “catastrophic coverage.” A reduced coinsurance amount or copayment will apply.

Medicare drug plans vary in which drugs they cover, what your out-of-pocket costs will be, and which pharmacies you can use.

Make sure you compare plans so you find a plan that best meets your needs. Look at:
- Coverage (formularies).
- Cost (premiums, deductibles and copays).
- Convenience (some plans offer network and mail-order pharmacies).
- Quality (plans’ performance ratings can be found at medicare.gov).

Annual open enrollment is Oct. 15 to Dec. 7. There are exceptions, such as if you move to another state or reach Medicare age. Policies generally take effect Jan. 1.

Get help finding a drug plan

Contact CLAIM: missouriclaim.org 800-390-3330
Contact Medicare: medicare.gov

Enrollment

- If you don’t join a Medicare drug plan when you are first eligible for Medicare Part A and/or Part B, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage.
- You can switch your Medicare Part D plan during the annual open enrollment period, which is Oct. 15 to Dec. 7. Your new coverage will begin Jan. 1.
- There are circumstances that can generate a special open enrollment period. Call CLAIM at 800-390-3330 for information.
- You should review your drug coverage during every annual open enrollment period, to make sure you still have the best plan for you.
- Before you buy a drug plan, it is important to make sure the plan you are considering is approved by Medicare. Contact CLAIM at 800-390-3330 or visit Medicare’s website at medicare.gov.
Changes in Your Medicare Part D Prescription Drug Plan
Closing the Coverage Gap

The Affordable Care Act outlines major changes to your Medicare Part D Prescription Drug Plan. These changes are designed to assist consumers with their prescription drug costs. Between 2015 and 2020, the amount you pay while in the “doughnut hole” is going to decrease. Please see the chart below to determine what percentage you will pay for brand-name and/or generic drugs during your coverage gap.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>% You’ll Pay for Brand-Name Drugs</th>
<th>% You’ll Pay for Generic Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>45%</td>
<td>65%</td>
</tr>
<tr>
<td>2016</td>
<td>45%</td>
<td>58%</td>
</tr>
<tr>
<td>2017</td>
<td>40%</td>
<td>51%</td>
</tr>
<tr>
<td>2018</td>
<td>35%</td>
<td>44%</td>
</tr>
</tbody>
</table>

For more information on the upcoming changes to your Medicare Part D Prescription Drug Plan, please visit the Centers for Medicare & Medicaid Services (CMS) website at: https://www.medicare.gov/Pubs/pdf/11493.pdf.

You may also contact CMS by calling 1-800-MEDICARE (1-800-633-4227).
Missouri Rx Plan: Help with drug costs

Basic facts
The Missouri Rx Plan (MoRx) helps cover some of the out-of-pocket costs you pay with Medicare Part D. It is available to qualifying elderly and disabled Medicare beneficiaries. The Missouri Department of Social Services, MO HealthNet Division, administers the program.

Members must be enrolled in a Medicare prescription drug plan to receive benefits from the Missouri Rx Plan.

Benefits
- MoRx pays for half of the deductible and half of all copays, including the coverage gap (see previous page). It does not provide assistance with the monthly premium.
- The MoRx benefit is not available for mail order prescription service through the Part D plan.
- MoRx covers a maximum of a 31-day supply per prescription fill per month. The MoRx benefit is not available for 90-day supply purchases.

Enrollment
- No cost or enrollment fee to join.
- Look for MoRx one-page applications at pharmacies, Area Agencies on Aging, county health departments and public libraries, Department of Revenue license bureaus and MFA Agri-Service centers.
- MoRx applications can also be obtained by calling toll-free 800-375-1406, calling CLAIM at 800-390-3330 or downloaded from morx.mo.gov.
- MoRx enrollment is ongoing. No annual re-enrollment is required.

How to get a MoRx application
Call: 800-375-1406
Visit: morx.mo.gov
Local businesses, agencies that might have applications:
- Pharmacy
- Area Agency on Aging
- County health department
- County public library
- Motor vehicle license bureau
- MFA Agri-Service Center

Eligibility requirements
Medicare beneficiaries with incomes at or below:
- $21,660 annual income for an individual.
- $29,140 annual (combined) income for a married household.
- No asset or resource limitations apply.
Medicare Advantage plans: What you need to know

Medicare Advantage plans are available from private companies that contract with the Centers for Medicare and Medicaid Services to provide Medicare benefits to enrollees. The plans must provide all benefits provided by Medicare. They may also provide additional benefits.

Members pay the plan premium, if any. Plans may charge copayments or coinsurance amounts for various services.

At the end of each year, companies offering plans may change the premium, the services offered, the service area or they may choose to leave the Medicare program entirely.

The annual open enrollment period to join or leave a Medicare Advantage plan is Oct. 15 to Dec. 7. Your new coverage will begin Jan. 1 of the following year.

Study your choices and sales material carefully before enrolling in a Medicare Advantage plan. Compare each plan to others available in your area. If you already have insurance, do not cancel it before you receive notice the new plan has been issued and that it offers the promised benefits.

ENROLLMENT
To enroll in a Medicare Advantage plan, you must:
- Have Medicare Parts A and B; and
- Pay a Part B premium; and
- Not have end-stage renal disease (kidney failure)

Have questions about Medicare Advantage plans? Call CLAIM for a referral to a CLAIM counselor in your local area. It is free.

800-390-3330
# Medicare with

## Medigap vs. Medicare Advantage

<table>
<thead>
<tr>
<th>What health care benefits are covered?</th>
<th>Traditional Medicare A &amp; B plus Medigap policy</th>
<th>Medicare Advantage Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medicare A and B benefits. Medigap policy benefits depend on the plan purchased. Refer to each policy for details.</td>
<td>All the Medicare A and B benefits and perhaps others, depending on the plan. Some plans may offer other coverage. Refer to plan for details.</td>
<td></td>
</tr>
</tbody>
</table>

| Are outpatient prescription drugs covered? | No. | It depends on the plan. See each plan for any drug coverage. |

| Can I go to any doctor or hospital? | You can go to any doctor, specialist or hospital that accepts Medicare. | You may go to any doctor, specialist or hospital that has a contract with the plan. |

| Does the policy/plan let doctors or hospitals charge more than Medicare’s deductibles, coinsurance and copayments? | Not for hospitals, but possibly for doctors. Doctors who do not accept Medicare assignment may charge up to 15 percent more than Medicare’s approved amount. (Part B excess charges are covered under plans F and G.) | Medicare Advantage sets the rates for deductibles, coinsurance and copayments for the plan. Refer to plan for details. |

| How are claims paid? | The provider sends the claim to Medicare. Medicare approves the amount of the claim and pays its portion. Medicare or the provider forwards the claim to the Medigap policy which, according to the policy requirements, may or may not pay the remaining balance. | Prior to receiving care, the plan member pays a copayment/deductible amount. The provider sends the claim to the Medicare Advantage plan. The plan approves the claim amount and pays its share. The member pays any remaining share – such as a deductible, coinsurance or copayment – if the plan allows balance billing. Refer to plan for details. |
Insurance terms

**Appeal:** A complaint you file with your insurance company or Medicare if you disagree with a decision about coverage. You can appeal if you are denied coverage for a treatment, supply or drug prescription, or if the coverage is less than you think it should be. You can also appeal if you are already receiving coverage and the plan stops paying.

**Coinsurance:** The amount you pay for services after you pay deductibles. In Original Medicare, this is a percentage (like 20 percent) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible. In a prescription drug plan (Part D), the coinsurance will vary.

**Copayment:** In some Medicare plans, the amount you pay for each medical service such as a doctor’s visit or prescription. A copayment is usually a set amount, for example $10 or $20. Copayments are also used for some hospital outpatient services.

**Creditable prescription drug coverage:** Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Deductible:** The amount you pay for health care or prescriptions before insurance benefits kick in. So if you have a $1,000 deductible, you have to pay that much out of your pocket during the year before insurance begins paying. These amounts can change every year.

**Formulary:** A list of drugs covered by a plan.

**Guaranteed issue rights:** Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company cannot deny you a Medigap policy and you cannot be charged more because of a past or present health problem. Coverage of pre-existing conditions starts immediately if you have had at least six months of prior coverage. The pre-existing condition period is offset month for month if you have had less than six months of coverage.
Health maintenance organization (HMO) plan: A type of Medicare Advantage plan. Extra benefits like dental or vision coverage may be offered. In most HMOs, you can only go to network doctors, specialists or hospitals on the plan’s list except in an emergency.

Long-term care: Assistance with everyday functions, like bathing and dressing, usually provided in a nursing home or at home through a home-health service. Generally, Medicaid pays for long-term care, but Medicare does not.

Medicaid: A joint federal and state program that helps with medical costs for some people with limited income and resources.

Medicare Advantage plan (Part C): A type of Medicare plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called Part C, Medicare Advantage plans are HMOs, PPOs, private fee-for-service plans, or Medicare medical savings account plans. Some Medicare Advantage plans offer prescription drug coverage.

Medicare-approved amount: In Original Medicare, this is the amount a doctor or supplier that accepts assignment is paid. It includes what Medicare pays and any deductible, coinsurance or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare prescription drug plan (Part D): A stand-alone drug plan offered by insurers and other private companies to those who get benefits through Original Medicare. Medicare Advantage plans may also offer prescription drug coverage and must follow the same rules as Medicare prescription drug plans.

Medigap: Medicare Supplemental insurance sold by private insurance companies to pay deductibles, copayments and coinsurance in Original Medicare coverage. Medigap policies only work with Original Medicare.

Original Medicare: Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). It is a fee-for-service health plan. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance, copayments and deductibles).

Network: A group of physicians, hospitals and other health care professionals who provide health care services for Medicare Advantage plans and select plans.

Penalty: An amount added to your monthly premium for Medicare Part B, or for a Medicare drug plan (Part D), if you don’t join when you’re first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

Point-of-service plan: A health maintenance organization (HMO) option that lets you use doctors and hospitals outside the plan for an additional cost.

Preferred provider organization (PPO) plan: A type of Medicare health plan available in a local or regional area in which you pay less if you use doctors, hospitals and providers that belong to the network. You can use doctors, hospitals and providers outside of the network for an additional cost. Extra benefits like dental or vision coverage may be offered. Many Medicare Advantage plans are PPOs.
Insurance terms (continued)

**Premium:** Your periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage. Example: $179 per month.

**Preventive services:** Care intended to keep you healthy (for example, Pap tests, pelvic exams, flu shots and cancer screenings).

**Primary care doctor:** Also known as a gatekeeper, the primary care physician is responsible for coordinating your care in a managed care plan. He or she makes sure you get the care you need to keep you healthy. In many Medicare Advantage plans, you must see your primary care doctor before you see a specialist or other health care provider.

**Private fee-for-service (PFFS) plan:** A type of Medicare Advantage plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan’s payment. The insurance plan, rather than Medicare, decides how much it will pay and what you pay for the services you get. Extra benefits like dental or vision coverage may be offered. You may pay more or less for Medicare-covered benefits.

**Skilled nursing facility care:** This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples include intravenous injections and physical therapy. The need for only custodial care (help with daily living activities such as bathing and dressing) cannot qualify you for Medicare coverage in a skilled nursing facility.

**State Health Insurance Assistance Program:** A state program funded by federal and state grants to give free counseling to people on Medicare. In Missouri, this is the CLAIM program. See inside front cover for details.

**Underwriter:** Insurance company employee who figures out how risky it is to insure clients. Underwriters decide what coverage an applicant qualifies for and what rates you should pay, or whether to accept or deny your application.
We’re here to help you
Seniors and other Missouri consumers who have questions about their insurance policy or want to file a complaint against an insurance company or agent are encouraged to call DIFP’s hotline:

Insurance Consumer Hotline

800-726-7390
Contact DIFP’s Insurance Consumer Hotline

For questions about your insurance policy or to file a complaint against an insurance company or agent:

difp.mo.gov
800-726-7390

REVISED MARCH 2017

Harry S Truman Building, Room 530
301 W. High St.
PO Box 690
Jefferson City, MO 65102
Missouri Medigap issuers: Complaint index for 2008-2010

Besides rates, consider a company’s complaint index. This score helps you understand how many consumer complaints an insurer receives, compared to other companies its size.

<table>
<thead>
<tr>
<th>Company</th>
<th>Complaint index</th>
<th>Complaints</th>
<th>Average market share</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admiral Life Insurance Co. of America</td>
<td>147</td>
<td>4</td>
<td>1.3%</td>
<td>800-987-1593</td>
</tr>
<tr>
<td>American Continental Insurance Co.</td>
<td>72</td>
<td>2</td>
<td>1.3%</td>
<td>800-264-4000</td>
</tr>
<tr>
<td>American Republic Corp Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.3%</td>
<td>800-247-2190</td>
</tr>
<tr>
<td>American Republic Insurance Co.</td>
<td>61</td>
<td>5</td>
<td>3.9%</td>
<td>800-247-2190</td>
</tr>
<tr>
<td>Bankers Fidelity Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>866-458-7500</td>
</tr>
<tr>
<td>Blue Cross &amp; Blue Shield Of Kansas City</td>
<td>59</td>
<td>7</td>
<td>5.7%</td>
<td>800-645-8346</td>
</tr>
<tr>
<td>Christian Fidelity Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>2.9%</td>
<td>800-386-5202</td>
</tr>
<tr>
<td>Colonial Penn Life Insurance Co.</td>
<td>496</td>
<td>1</td>
<td>0.1%</td>
<td>877-877-8052</td>
</tr>
<tr>
<td>Combined Insurance Co. of America</td>
<td>0</td>
<td>0</td>
<td>0.8%</td>
<td>800-544-5531</td>
</tr>
<tr>
<td>Consec Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>800-541-2254</td>
</tr>
<tr>
<td>Continental General Insurance Co.</td>
<td>216</td>
<td>1</td>
<td>0.2%</td>
<td>800-545-8905</td>
</tr>
<tr>
<td>Equitable Life &amp; Casualty Insurance Co.</td>
<td>66</td>
<td>1</td>
<td>0.7%</td>
<td>800-352-5170</td>
</tr>
<tr>
<td>Family Life Insurance Co.</td>
<td>1,361</td>
<td>1</td>
<td>0.0%</td>
<td>800-877-7703</td>
</tr>
<tr>
<td>Gerber Life Insurance Co.</td>
<td>508</td>
<td>1</td>
<td>0.1%</td>
<td>800-253-3074</td>
</tr>
<tr>
<td>Globe Life &amp; Accident Insurance Co.</td>
<td>693</td>
<td>3</td>
<td>0.2%</td>
<td>800-801-6831</td>
</tr>
<tr>
<td>Government Personnel Mutual Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>866-800-5566</td>
</tr>
<tr>
<td>Healthy Alliance Life Insurance Co.</td>
<td>141</td>
<td>44</td>
<td>14.9%</td>
<td>866-438-9969</td>
</tr>
<tr>
<td>Heartland National Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.3%</td>
<td>877-431-7371</td>
</tr>
<tr>
<td>Humana Insurance Co.</td>
<td>3,478</td>
<td>10</td>
<td>0.1%</td>
<td>866-205-0000</td>
</tr>
<tr>
<td>Liberty National Life Insurance Co.</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>800-288-2722</td>
</tr>
</tbody>
</table>

NA = Company did not sell policies for all three years

What complaint index means

100 score: Insurer gets average number of complaints.  
Below 100: Insurer gets fewer complaints than average.  
Above 100: Insurer gets more complaints than average.
<table>
<thead>
<tr>
<th>Company</th>
<th>Complaint index</th>
<th>Complaints</th>
<th>Average market share</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln National Life Insurance Co.</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>860-466-1492</td>
</tr>
<tr>
<td>Loyal American Life Insurance Co.</td>
<td>263</td>
<td>1</td>
<td>0.2%</td>
<td>800-633-6752</td>
</tr>
<tr>
<td>Marquette National Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.1%</td>
<td>800-934-8203</td>
</tr>
<tr>
<td>Medico Insurance Co.</td>
<td>66</td>
<td>2</td>
<td>1.4%</td>
<td>800-228-6080</td>
</tr>
<tr>
<td>Mutual Of Omaha Insurance Co.</td>
<td>91</td>
<td>8</td>
<td>4.2%</td>
<td>877-845-0892</td>
</tr>
<tr>
<td>Old Surety Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.1%</td>
<td>800-272-5466</td>
</tr>
<tr>
<td>Oxford Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>877-469-3073</td>
</tr>
<tr>
<td>Physicians Mutual Insurance Co.</td>
<td>62</td>
<td>1</td>
<td>0.8%</td>
<td>800-228-9100</td>
</tr>
<tr>
<td>Reserve National Insurance Co.</td>
<td>99</td>
<td>1</td>
<td>0.5%</td>
<td>800-654-9106</td>
</tr>
<tr>
<td>Standard Life &amp; Accident Insurance Co.</td>
<td>327</td>
<td>6</td>
<td>0.9%</td>
<td>888-350-1488</td>
</tr>
<tr>
<td>State Farm Mutual Automobile Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>1.9%</td>
<td>866-855-1212</td>
</tr>
<tr>
<td>State Mutual Insurance Co.</td>
<td>266</td>
<td>1</td>
<td>0.2%</td>
<td>855-764-4000</td>
</tr>
<tr>
<td>Sterling Investors Life Insurance Co.</td>
<td>31</td>
<td>1</td>
<td>1.5%</td>
<td>877-604-5240</td>
</tr>
<tr>
<td>Sterling Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.1%</td>
<td>888-858-8544</td>
</tr>
<tr>
<td>Thrivent Financial For Lutherans</td>
<td>94</td>
<td>1</td>
<td>0.5%</td>
<td>800-847-4836</td>
</tr>
<tr>
<td>Transamerica Life Insurance Co.</td>
<td>322</td>
<td>7</td>
<td>1.0%</td>
<td>800-233-4624</td>
</tr>
<tr>
<td>United American Insurance Co.</td>
<td>72</td>
<td>2</td>
<td>1.3%</td>
<td>972-529-5085</td>
</tr>
<tr>
<td>United Commercial Travelers</td>
<td>0</td>
<td>0</td>
<td>0.1%</td>
<td>800-848-0123</td>
</tr>
<tr>
<td>United Healthcare Insurance Co. (individual)</td>
<td>38</td>
<td>20</td>
<td>25.3%</td>
<td>800-627-0687</td>
</tr>
<tr>
<td>United Healthcare Insurance Co. [AARP]</td>
<td>38</td>
<td>20</td>
<td>25.3%</td>
<td>800-272-2146 (AARP)</td>
</tr>
<tr>
<td>United National Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>847-803-5252</td>
</tr>
<tr>
<td>United of Omaha Life Insurance Co.</td>
<td>113</td>
<td>11</td>
<td>4.6%</td>
<td>800-228-9999</td>
</tr>
<tr>
<td>United World Life Insurance Co.</td>
<td>142</td>
<td>8</td>
<td>2.7%</td>
<td>877-845-0892</td>
</tr>
<tr>
<td>USAA Life Insurance Co.</td>
<td>0</td>
<td>0</td>
<td>0.3%</td>
<td>800-292-8556</td>
</tr>
<tr>
<td>Washington National Insurance Co.</td>
<td>358</td>
<td>9</td>
<td>1.2%</td>
<td>800-888-4918, x 5954</td>
</tr>
<tr>
<td>World Corp Insurance Co.</td>
<td>916</td>
<td>1</td>
<td>0.1%</td>
<td>800-786-7557</td>
</tr>
</tbody>
</table>
**Buying a Medigap plan worksheet**

When you call an insurance company about a Medigap policy, here are some questions you might want to ask. Write down the responses for later reference.

<table>
<thead>
<tr>
<th>DATE</th>
<th>PHONE NUMBER</th>
<th>PLAN LETTER</th>
<th>COMPANY NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMPANY REPRESENTATIVE’S NAME and TITLE**

How much is the monthly premium for plan? __________________________________________________________________________________

How long has the company been selling Medigap policies? __________________________________________________________________________

When did the plan’s rate last increase? How many increases in last three years? __________________________________________________________________________

When do you expect to have another rate increase? __________________________________________________________________________

How many complaints has your company received in the last 12 months? ______________________________________________________________________

What is the most common complaint your company receives? __________________________________________________________________________

Why should I buy a policy from this company? __________________________________________________________________________________

How long does it take for your company to pay a claim? __________________________________________________________________________

What is A.M. Best’s financial rating of your company? (They range from A++ to F) __________________________________________________________________________

Is this plan underwritten? (See page 22 for definition.) __________________________________________________________________________

Is this a group plan and, if so, how do I join the group? __________________________________________________________________________
### Medigap insurance plan options

<table>
<thead>
<tr>
<th>PLANS</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>F</th>
<th>F high deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic benefits</td>
<td>Basic benefits</td>
<td>Basic benefits</td>
<td>Basic benefits</td>
<td>Basic benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part A deductible</td>
<td>Part A deductible</td>
<td>Part A deductible</td>
<td>Part A deductible</td>
<td></td>
<td></td>
<td>This option has the same benefits as Plan F but a high deductible first must be paid. The trade-off is a lower monthly premium. The beneficiary pays the plan’s deductible each year before the supplemental policy pays for any services. This deductible amount is subject to increase each year.</td>
</tr>
<tr>
<td>Skilled nursing coinsurance</td>
<td>Skilled nursing coinsurance</td>
<td>Skilled nursing coinsurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B deductible</td>
<td></td>
<td>Part B deductible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B excess (100%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign travel emergency</td>
<td>Foreign travel emergency</td>
<td>Foreign travel emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Explanation of Medigap plan benefits

**Basic benefits**  
(Plans A-N)

- Coverage for coinsurance for day 61-90 of inpatient hospitalization.
- Coverage for coinsurance for lifetime reserve days 91-150.
- Coverage for an additional 365 days of inpatient hospital care in your lifetime.
- Coverage for first three pints of blood.
- Coverage for 20% coinsurance for Part B services.
- Coverage for the hospice 5% coinsurance for Medicare-approved charges for inpatient respite care and 5% coinsurance for prescription pain medications.

**Part A deductible**  
(Plans B, C, D, F, G, N)  
(Partial coverage on K, L, M)

- Coverage for inpatient hospital deductible for each benefit period.
- Partial coverage on Plans K, L and M.
**Medigap insurance plan options** continued

<table>
<thead>
<tr>
<th></th>
<th>G</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic benefits</strong></td>
<td>Hospitalization, preventive care paid at 100%; other basic benefits paid at 50%</td>
<td>Hospitalization, preventive care paid at 100%; other basic benefits paid at 75%</td>
<td>Basic benefits</td>
<td>Basic benefits, except up to $20 copay for office visit &amp; up to $50 copay for ER</td>
<td></td>
</tr>
<tr>
<td><strong>Part A deductible</strong></td>
<td>50% of Part A deductible</td>
<td>75% of Part A deductible</td>
<td>50% of Part A deductible</td>
<td>Part A deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing coinsurance</strong></td>
<td>50% of skilled nursing coinsurance</td>
<td>75% of skilled nursing coinsurance</td>
<td>Skilled nursing coinsurance</td>
<td>Skilled nursing coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Part B excess (100%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Foreign travel emergency</strong></td>
<td>Benefits paid at 100% after out-of-pocket limit reached</td>
<td>Benefits paid at 100% after out-of-pocket limit reached</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explanation** continued

**Skilled nursing coinsurance** (Plans C, D, F, G, M, N) (Partial coverage on K, L)
- Coverage for skilled nursing coinsurance for days 21-100 for each benefit period.
- Partial coverage on Plans K & L.

**Part B deductible** (Plans C, F)
- Coverage for the yearly deductible.

**Part B excess** (Plans F, G)
- Coverage for Part B charges over approved amount.
- Plan F pays for 100% of excess charge.
- Plan G pays for 100% of excess charge.

**Foreign travel emergency** (Plans C, D, F, G, M, N)
- Coverage for emergency care for first 60 days of a trip outside the U.S.
- Beneficiary pays for $250 deductible and 20% of cost up to $50,000.