MISSOURI DEPARTMENT OF SOCIAL SERVICES FAMILY SUPPORT DIVISION

BREAST AND CERVICAL CANCER TREATMENT (BCCT) MO HEALTHNET APPLICATION

Missouri Department of SOCIAL SERVICES

SHOW ME HEALTHY WOMEN (SMHW) PROVIDER
TELEPHONE NUMBER
DIAGNOSIS DATE

Send Completed Application to:
Family Support Division
PO Box 2320
Jefferson City, MO 65201-2320
FAX: 573-751-3091

FOR OFFICE USE ONLY
DATE APPLIED
DCN

A. MAILING ADDRESS

NAME (FIRST, MIDDLE, LAST)	MAIDEN NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RACE/ETHNICITY

ADDRESS (STREET, RURAL ROUTE, OR PO BOX), CITY, STATE, ZIP CODE

TELEPHONE NUMBER	Does this phone accept text message? ☐ YES ☐ NO	EMAIL

B. INSTRUCTIONS: Please answer each question completely.

	YES	NO
1. Were you born in Missouri?	☐	☐
2. Are you a U.S. citizen? If **No**, list immigration status, registration number, and date of entry:	☐	☐
3. Do you currently have health care insurance?	☐	☐

NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
	☐ DOCTOR ☐ HOSPITAL **If limited coverage explain:**

	YES	NO
4. Do you have children under the age of 19 residing in your home?	☐	☐
5. Are you pregnant?	☐	☐
6. Are you blind?	☐	☐
7. Are you disabled?	☐	☐

C. PLEASE READ CAREFULLY AND SIGN BELOW:

- I agree to provide Social Security numbers of all persons applying for MO HealthNet as required by law. The Social Security number is used to determine eligibility and verify information.
- I agree that my statements and information provided may be verified.
- I will report any changes in circumstances within **TEN DAYS** of when they happen.
- I know that it is against the law to obtain benefits to which I am not entitled. Any false claim, statement or concealment of any material fact whatsoever, in whole or in part, may subject me to criminal and/or civil prosecution.
- I agree that medical information about me can be released if needed to administer this program.
- I understand healthcare benefits based on a person being blind, disabled, age 65 or over, pregnant women, child or parent, or a low income adult is not determined by completing this application. If I want eligibility for healthcare benefits explored on the basis of one of these, I must complete a different application for these benefits.
- Provided I am found to be eligible for MO HealthNet, I know the state of Missouri will pay for covered services on my behalf and agree the state may collect payments from any third party (i.e., insurance, estate, etc.) for services paid by the state.
- I understand that if I disagree with the decision concerning my eligibility, I may request a fair hearing within 90 days of the date of the decision.

I agree that the signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my knowledge.

If signing this application electronically, I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

SIGNATURE	DATE