MO HealthNet Application Process for the Elderly, Blind, and Disabled

6/11/18

Eligibility Groups

To receive MO HealthNet a person must be:

- age 65 or over (referred to as aged)
- blind
- disabled
- a child under age 19 (or age 21, if in state custody)
- a caretaker parent (or other relative) of a low-income child
- a pregnant woman
- *a woman in need of treatment for breast or cervical cancer*
- an individual under age 26 who was in foster care on the date they turned age 18 or 30 days prior

AND

- Meet the requirements of an eligibility category

ME CODES

MO HealthNet Eligibility (ME) codes identify the category of MO HealthNet that a person is in.

There are currently 75 ME codes in use.

- 6 are state only funded (no federal Medicaid match) with a limited benefit package
- 10 have a benefit package restricted to specific services
- 4 are the Children's Health Insurance Program (CHIP) premium program
- The others are federally matched categories that provide a benefit package based on whether the person is a child under 21, an adult, pregnant, blind, or in a nursing facility

Categories that Don’t Cover DMH Services

CPR, CSTAR, and DD waiver services are covered by all ME codes except the following that are either state only funded (*) or have a specific restricted benefit package(^).

- 02* – Blind Pension
- 08* – CWS Foster Care
- 52* – DYS General Revenue
- 55^ – QMB
- 57* – CWS-FC Adoption Subsidy
- 58^, 59*^, 94^ – Presumptive Eligibility for Pregnant Women
- 64*,65* - Group Home Health Initiative Fund
- 80^, 89^ – Uninsured Women’s Health Services
- 91^, 92^, 93^ – Gateway to Better Health
- 82*^ – Missouri Rx

Aged, Blind, Disabled (ABD) categories

- **MO HealthNet for the Aged, Blind, Disabled (MHABD)** – spend down/non-spend down, vendor for patients in nursing facilities or state institutions, Special Income Level (SIL) for Aged & Disabled HCB waiver, 1619(a)&(b), disabled children – ME codes 11, 12, 13
- **Ticket-to-Work Health Assurance (TWHA)** –ME codes 85, 86
- **Supplemental Nursing Care (SNC) –** ME codes 14,15,16
- **Supplemental Aid to the Blind (SAB)** – ME code 03
- **Blind Pension (BP)** – ME code 02
- **MOCDD (Sara Lopez) waiver** – ME codes 33,34

Aged, Blind, Disabled categories

- **Old Age Assistance conversion (OAA)** – ME code 01
- **Aid to the Permanently and Totally Disabled conversion (PTD)** – ME code 04
- **Aid to the Blind conversion (AB)** – ME code 03 (same as SAB)
- **Qualified Medicare Beneficiary (QMB)** – ME code 55
- **Specified Low Income Medicare Beneficiary (SLMB or SLMB1)** – no ME code as only benefit is payment of Medicare premium
- **Qualifying Individual (QI or SLMB2)** - no ME code as only benefit is payment of Medicare premium

Screen for MO HealthNet eligibility

1. **Is the person under age 19?**
   ___ Yes, submit application ___ No, continue screening
2. **Is the person pregnant**?
   ___ Yes, submit application ___ No, continue screening
3. **Is the person the parent of a child under age 19 who lives in the person's home?**___ Yes, submit application ___ No, continue screening
4. **Is the person age 65 or older?**
   ___Yes, submit application ___ No, continue screening
5. **Is the person receiving SSI or Social Security Disability benefits?**
   ___ Yes, submit application ___ No, continue screening
6. **Does the person have a medical condition, other than substance use, that prevents him or her from maintaining on-going employment at this time?**___ Yes, submit application ___ No, continue screening
7. **Is the person blind?**
   ___ Yes, submit application ___ No, the client is not eligible

How to apply

Elderly, blind, and disabled:

- **By mail or on-line:** Department of Social Services (DSS) web site, www.dss.mo.gov
  - On the right side of the home page, choose **"find medical coverage?"** under **"How do I . . ."**
  - Choose either "People with Disabilities", "Seniors", or "Blind or Visually Impaired"
    - Complete and submit on-line; or
    - Download an application and mail to the local Family Support Division (FSD) resource center, the locations are available on the DSS web site under "Find a Service by County -Food, Health Care, Family Care"
- **In-person**
  - At a local Family Support Division (FSD) resource center, no appointment required
  - At some hospitals and medical clinics
- **By phone**: call FSD Information Center toll free 1-888-275-5908

Missouri Department of SOCIAL SERVICES

MO.gov | Governor Jay Nixon | Find an Agency | Online Services | Search

Home | Children | Families | Health Care | Youth | Find Offices

Heart GALLERY of Missouri Adoption & Foster Care Information

Find a MO HealthNet Provider

myDSS Health Benefit Eligibility Tool

Report Child Abuse or Neglect

How do I...

- view child support payments?
- apply for child support services?
- check on my MO HealthNet application?
- report changes and check benefits?
- become an adoptive/foster parent?
- find medical coverage?
- access food stamps?
- report school violence?
- report fraud?
- find a provider?
- complete online childcare invoicing?
- send or open encrypted email?

Health Care - MO HealthNet (Medicaid)

What is MO HealthNet?

Missouri's Medicaid program is called MO HealthNet. MO HealthNet covers qualified medical expenses for individuals who meet certain eligibility requirements. Eligible individuals receive a "MO HealthNet Identification Card" or a letter from the Family Support Division identifying them as eligible for certain medical care services.

Frequently Asked Health Care Questions

Already Enrolled?/Find a Doctor

Family Support Services

- Child Support
- Food Assistance
- Health Care
- Temporary Assistance
- Blind Services
- Child Care
- All Services
- Find Offices/Contact FSD

Tell Us How We're Doing

Resources & Agency Partners

Know Your Rights

You have the right to a hearing if you have applied for or are receiving Financial Assistance, MO HealthNet, or Food Stamp Benefits.

Learn more about your rights.

Voter Registration Application

If you wish to register to vote, please download and complete the Voter Registration Form and return it to your local FSD office. This has no impact on your application or continued eligibility for assistance.

myDSS

DSS MO.gov Gov. Eric Greitens Find an Agency Online Services Search

yDSS Services Do I Qualify?/Apply Check My Status Report a Change Frequent Ques

ealthNet (Medicaid) for People with Disabilities

et (Medicaid) for People with Disabilities provides medical care for persons who are Permanently and Totally D) and meet other eligibility requirements. If you've already enrolled, go to MO HealthNet for assistance using or finding a doctor.

Apply Online

Paper Application

Accompanying Forms

only need if not on SSI or SSDI

l get help?

Instructions

Application Checklist

Frequently Asked Questions

Family Support Service

- Child Support
- Food Assistance
- Health Care
- Temporary Assistance
- Blind Services
- Child Care
- All Services
- Find Offices/Contact FSD

Tell Us How We're

Resources & Agency

bottom of People with Disabilities page

Additional Forms

- MO HealthNet Application
- Appointment of Authorized Representative
- Authorized Representative Revocation

Required

If you do not receive SSD or SSI, the following forms may be needed:

- Disability Questionnaire
- Work History-Past 10 Years
- Hospitals, Medical Facilities & Physicians Seen
- Authorization for Disclosure of Medical Information

Spend Down

- Provider Bulletin introducing Spend Down Unit
- MO HealthNet Spend Down Provider Form
- Provider Attestation of Physician's Order of Medical Necessity
- MO HealthNet Spend Down Transportation Expense Log
- Spend Down Brochure

Additional Program Information

- Aged, Blind and Disabled Program Descriptions
- Aged, Blind and Disabled Income and Asset Limit Chart

Other Programs

- Medicare Cost Savings Programs
- Nursing Home Coverage
- Home and Community Based Services
- Adult Supplemental Payments
- Prevention of Spousal Impoverishment

MRT Forms

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 informacion sobre los Servicios de Rehabilitación para Invidentes, por favor llame al 1-800-592-6004.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPLICATION FOR MO HEALTHNET (MEDICAID)

FOR OFFICE USE ONLY

DATE APPLIED

SECTION 1: Your Basic Information

DCN #1 | DCN #2

APPLICANT FULL LEGAL NAME (FIRST, MIDDLE, LAST) | MAIDEN NAME (IF ANY)

HOME ADDRESS (HOUSE NUMBER, STREET OR RURAL ROUTE, P.O.BOX, HOMELESS) | CITY, STATE, ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS) | CITY, STATE, ZIP CODE

PRIMARY PHONE NUMBER ☐ Cell ☐ Home ☐ Work ☐ Other: | ALTERNATE PHONE NUMBER ☐ Cell ☐ Home ☐ Work ☐ Other:

E-MAIL ADDRESS

PREFERRED METHOD OF CONTACT
☐ Call ☐ *Text ☐ E-mail ☐ Mail *Texting is not available in all locations.

SOCIAL SECURITY NUMBER | DATE OF BIRTH | PLACE OF BIRTH | RACE* (OPTIONAL) | SEX ☐ M ☐ F | HISPANIC (OPTIONAL) ☐ YES ☐ NO

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

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:

FACILITY NAME

FACILITY ADDRESS

☐ 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 7.

All applicants must fill out sections 2 through 7

Application Form IM-1A

Section 1:

- Basic Information – name, address, phone, SSN, DOB, etc.
- Reason applying:
  - Must check either over age 65, disabled- SSDI/SSI, Disabled – not SSDI/SSI, or Blind
  - If appropriate check in a nursing home or similar facility
  - If disabled and working check want coverage under Ticket to Work
  - Check need help with medical bills in the last 3 months if any medical services were received

Application Form IM-1A

Section 2 - Household:

- Instructions say to list anyone in the home, starting with a spouse, and to check who is applying.
- Must list the spouse.
- If the applicant is under age 18 and living with a parent, must the list the parents (including a step-parent) and siblings in the home.
- Do not need to include parents or siblings if the applicant is age 18 or over.
- Do not need to include roommates or other family members.

Application Form IM-1A

Section 3 – Money Available To You:

- Answer questions about ownership of cash, bank accounts, stocks, bonds, trusts, pre-paid burial plans, etc.

Section 4 – Income and Expenses:

- Only include income information for the applicant, their spouse (if in the home), and if the applicant is under age 18 their parents (if in the home)
- Only complete the expenses section if the applicant is in a skilled nursing facility and has a spouse living at home.

Application Form IM-1A

Section 5 – Citizenship and Residency:

- Check yes to resident of Missouri if no definite plans to move from the state
- Check yes to citizenship if appropriate, or enter immigration information.
- Check yes that the applicant will apply for other benefits such as Social Security, SSI, VA.

Section 6 – Personal Property:

- Answer questions about transfers of property, vehicles, real estate, and personal property.

Application Form IM-1A

Section 7 – Insurance

- Answer questions about life insurance, Medicare, Long-term care insurance and other health insurance.
- If residing in a residential care, assisted living, or non-Medicaid nursing facility or applying for blind cash assistance answer yes or no about derect deposit of benefits

Section 8 – Blind Pension and Supplemental Aid to the Blind

- Complete only if applying for blind cash assistance benefits

Authorized Representative

- A client may designate an individual or organization as the authorized representative for MO HealthNet by completing the IM-6AR form, which is available:
  - On the DSS website on the pages with information about the different eligibility groups.
  - From a link on the DMH Medicaid Eligibility page.

- The authorized representative will:
  - receive copies of requests sent to the client for additional information;
  - receive a copy of the final approval or denial notice;
  - be able to request an appeal on behalf of the client.

- A client may have multiple authorized representatives.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPOINTING AN AUTHORIZED REPRESENTATIVE

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.

If your authorized representative helps you apply, your authorization will last until the FSD makes a final decision on your application, or you can end it sooner if you tell the FSD in writing.
If your authorized representative acts on your behalf, your authorization will last until you end it by writing to the FSD.

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 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	DATE
YOUR SPOUSE'S SIGNATURE	

Authorized Representative form

In section 1 the client can designate an authorized representative to:

- Assist in applying for MO HealthNet
- Act on their behalf after approval of MO HealthNet with annual reviews and reporting changes
- Assist in applying for Food Stamp benefits
- Act on their behalf after approval for Food Stamp with annual reviews and reporting changes

Authorized Representative form

Section 2: the client designates an organization (DMH agency or facility) as the authorized representative for MO HealthNet to receive correspondence about their eligibility, which may include protected health information.

Section 3: this should be left blank if an organization is being assigned as the authorized representative

Section 4: this should be completed and signed by the organization representative.

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)	

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 applicants 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.

Application Time Limits

- Applications are required to be processed within:
  - 45 days for the aged (65 and over)
  - 90 days for the disabled and blind

- Applications can be held longer if the delay is not the fault of the client, such as waiting on medical records or other information from a third party.

- FSD policy requires two requests be sent before an application can be rejected for failure to provide verification.

- If requested information is received after the rejection, but prior to the original due date the client can be approved without submitting a new application.

RUSH Applications

Community Mental Health Centers, CSTAR providers, and DMH DD case managers may submit applications for some disabled clients they are assisting to FSD with a RUSH coversheet.

The coversheet and a flow chart for it's use are available on the DMH web site Medicaid Eligibility page:

https://dmh.mo.gov/ada/provider/rapidmedicaideligibility.html

RUSH Cover Sheet

Use the RUSH cover sheet for DMH consumers needing Medicaid as quickly as possible when:

- your agency assisted in completing the MRT packet, and
  - has medical records that show the client is disabled, or
  - will be assisting in gathering needed verification.

Or

- the client is receiving SSDI/SSI and your agency will be assisting in gathering needed verification.

RUSH

DATE: ___/___/___

Send applications, MRT packet, medical records, and verification to
FSD Greene County Office
101 Park Central Square
Springfield MO 65806
FSD.Hospitalapplications@dss.mo.gov
Fax: 417-895-6080

Re: Department of Mental Health (DMH) consumer:

Name: _____
Date of Birth: ___/___/___
DCN: 0 0 _ _ _ _ _ _ _ _ _ _
GAF score: _____

From DMH Agency/Provider:

Agency/Provider Name: _____
Address: _____
Contact Person: _____
Contact Phone Number: _____
Contact Email Address: _____

Documents Included:

For the application to be processed as a RUSH the MRT Packet documents must be included (unless the consumer is receiving SSDI and/or SSI in which case the MRT Packet is not needed.)

- ☐ Application (https://mydss.mo.gov/healthcare/mo-healthnet-for-people-with-disabilities)
- ☐ Authorized Representative Form
- ☒ Complete MRT Packet made up of all of the below documents:
  - ☒ IM-61B – Disability Questionnaire
  - ☒ IM-61C – Work History
  - ☐ Proof of application to SSD/SSI
  - ☐ IM-61C – Work History
  - ☒ MO 650-2616 – Authorization for Disclosure
- ☐ Medical / Behavioral Health Records included (if this is left blank, check one of the boxes below)
  - ☐ Client is receiving SSDI and/or SSI; records to establish disability are not needed
  - ☐ Being sent separately on a future date (mail to MRT.Personnel@dss.mo.gov or fax to 417-895-6152 if the application has already been submitted)
  - ☐ No records available/accessible for this client at this DMH Agency/Provider
- ☐ *Optional: IM-60A – Medical Report including Physician's Certification/Disability Evaluation*
- ☐ Notes_____

Only to be completed by Agency/Provider Representative.
Do not submit without completing all sections of this form. Do not distribute this to consumers.
Use this form for applications that need to be processed quickly for the wellbeing of the consumer.

09/2017

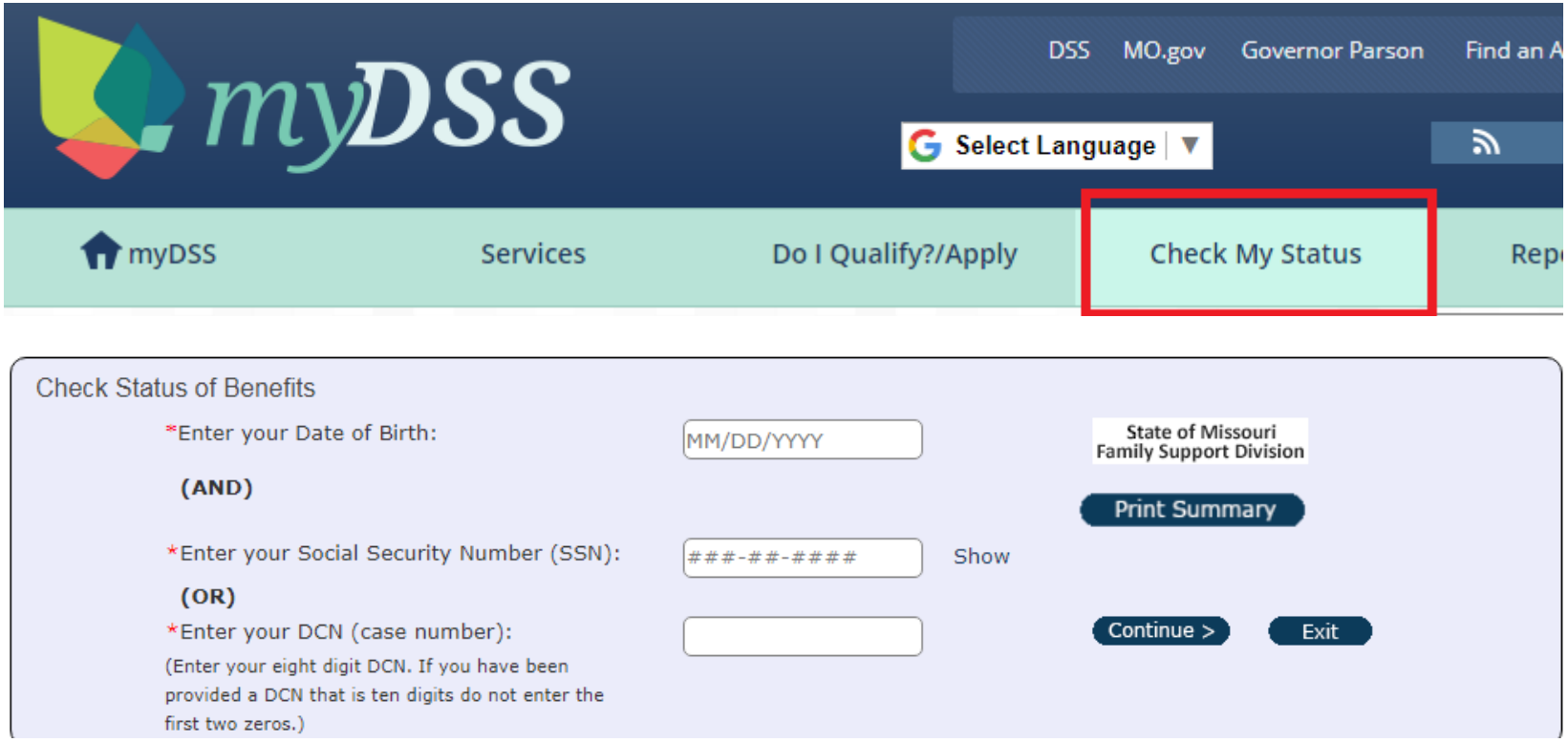
RUSH Cover Sheet

Include on the cover sheet:

- the consumer's name, date of birth, and if possible DCN
- name of the DMH agency submitting the application – CMHC, CSTAR provider, Regional Office, etc.
- a contact person at the agency
- check the documents included – unless receiving SSDI/SSI MUST always have the IM-61B,IM-61C, IM-61D, and MO 650-2616

Check Case Status

https://mydss.mo.gov/healthcare



Client can enter DOB and SSN or DCN to check case status.

Check Case Status Examples

Initial application pending on verification:

Medical Assistance Benefit Summary

Case Information:

Case Status	Household Member(s)	Eligibility Review Due
Application	[redacted]	

Application Information:

Application Type	Household Member(s)	Received Date	Due Date
Initial	[redacted]	05/17/2018	08/14/2018

Verification Requested:

Requested Information	Request Date	Due Date
LIFE INSURANCE/FIDELITY LIFE	05/21/2018	05/31/2018

Check Case Status Examples

Approved case:

Medical Assistance Benefit Summary

Case Information:

Case Status	Household Member(s)	Eligibility Review Due
Active	[redacted]	03/31/2019

Current Benefit Information:

Customer Name	Coverage Type	Current Coverage Start	Current Coverage End
[redacted]	Mo HealthNet for Aged, Blind or Disabled Non Spend Down	03/01/2018	

Premium/Spend Down Payment Information:

Customer Name	Coverage Type	Monthly Spend Down	Amount Met	Amount Remaining	As Of Date
[redacted]	Mo HealthNet for Aged, Blind or Disabled Non Spend Down	$ 0	$ 0	$0	06/07/2018

Check Case Status Examples

Closed case:

Medical Assistance Benefit Summary

Case Information:

Case Status	Household Member(s)	Closed/Rejected Due
Closed	[redacted]	05/01/2018

Rejected case:

Medical Assistance Benefit Summary

Case Information:

Case Status	Household Member(s)	Closed/Rejected Due
Rejected	[redacted]	04/18/2018

Eligibility factors that apply to all ABD categories

- Age 65 or over, blind, or disabled
- US Citizen or an eligible qualified legal immigrant
  - Immigrants must be in the U.S. for 5 years to be eligible for Medicaid, unless admitted as a refugee or a similar status
- Missouri Resident
  - Currently live in Mo., with the intent to remain permanently or indefinitely.
  - Does not required a fixed residence
- Social Security Number (except BP)
- Assets
- Income (Except BP)

Eligibility factors that apply to some categories

- **Living arrangement** – SNC, Vendor
- **Age** – SNC, SAB, BP, TWHA, Vendor MHC, Vendor Psychiatric Facility, Special Income Level (SIL) category for HCB Aged & Disabled and MOCDD waivers,
- **Medical need for institutional care** – Vendor, HCB, MOCDD
- **Division of Assets** - Vendor, SIL
- **Transfer of Assets** - Vendor, SIL
- **Employed**(paying Social Security/Medicare taxes)–TWHA
- **Premium** – TWHA individual's with gross income above 100% FPL must pay a monthly premium

Eligibility factors that apply to cash assistance programs for the blind

- **Not soliciting alms** – BP, SAB
- **Support from a sighted spouse** – BP, SAB
- **Ineligible for SSI and SAB** – BP
- **Good Moral Character** – BP
- State Ophthalmologist determines if participant meets Missouri's definition of blindness (5/200)

Citizenship/Immigrant requirement

- Must be U.S. citizen or eligible qualified legal immigrant
- Documentation requirement
  - Citizenship
  - Immigration Status
- Exempt from citizenship documentation if receiving
  - SSI
  - Medicare
  - Social Security Disability Insurance (SSDI)
- Reasonable opportunity to provide documentation after approval

Immigrants

- Eligibility based on qualified or non-qualified immigration status and date of entry into the U.S.
- Qualified immigrants eligible without waiting period
  - Certain refugees, asylees, Cubans/Haitians Entrants, and a few others
- Qualified immigrants after a 5 year waiting period
  - Lawful permanent resident, battered immigrants, and a few others
- Non-qualified immigrants are not eligible

* Immigrants ineligible ONLY due to the waiting period or being in a non-qualified status qualify for coverage of emergency medical care for aliens

Asset Limits

All categories for aged, blind, and disabled have asset limits

- MO HealthNet based on OAA/PTD and TWHA – available resources cannot exceed $2,000 (individual) or $4,000 (couple)
- MO HealthNet based AB, SAB & SNC for the blind – real and personal property cannot exceed $2,000 (individual) or $4,000 (couple)
- Blind Pension – total property cannot exceed $20,000
- QMB, SLMB, QI, - available resources cannot exceed $7,390 (individual) or $11,090 (couple)
- Supplemental Nursing Care – for elderly and disabled available resources cannot exceed $999.99 (individual) or $2,000 (couple)
- Home Equity limit of $560,000 – Vendor, HCB
- The client's home is not considered in determining available resources, real and personal property, or total property

There are no asset limits for the Family Healthcare categories

Asset Limit Change

Prior to July 1, 2017 the asset limits for MO HealthNet based on OAA/PTD and TWHA were $999.99 (for individuals), $2,000 (for married couple) and for MO Health based on AB $2,000/$4,000. HB1565 (2016) increased the limits to:

- $2,000 (individual)/$4,000 (couple) effective 7/1/17
- $3,000 (individual)/$6,000 (couple) effective 7/1/18
- $4,000 (individual)/$8,000 (couple) effective 7/1/19
- $5,000 (individual)/$10,000 (couple) effective 7/1/20
- Beginning 7/1/21 increases annually based on the COLA

HB 1565 also excludes Health Savings Accounts and Independent Living Accounts as available assets effective July 1, 2017.

ABLE Accounts

Achieving a Better Life Experience ("ABLE") accounts

- Established by federal legislation signed in December 2014.

- Allow an individual whose disability developed before age 26 to save money to help maintain health, independence, and quality of life without affecting eligibility for MO HealthNet, Food Stamps, and other federally funded assistance program.

- Can be set up through the Missouri State Treasurer's Office or another state's qualifying ABLE program.

ABLE Accounts

- Contributions can be may by the individual beneficiary of the account or a third party, but total contributions are limited to $15,000 per year.
- Account balances are not counted as an available resource.
- Contributions from a third party and earnings credited to an ABLE account are not counted as income.
- Distributions from an ABLE account for qualified disability expenses are not counted as income.

ABLE Accounts

Qualified disability expenses are any expense related to the person's disability, including:

- Basic Living Expenses
- Housing
- Transportation
- Education
- Employment Training and Support
- Personal Support Services
- Health & Wellness

Age Limits

- Supplemental Nursing Care (SNC) – age 21 and over
- SAB and Blind Pension (BP) – age 18 and over
- Vendor in a state mental hospital – age 65 and over
- Vendor in a psychiatric facility – under age 22
- TWHA – ages 16 through 64
- HCB Aged & Disabled waiver SIL - age 63 and over
- MOCDD waiver – under age 18

Disability

Definition for Medicaid is the same as the Social Security Act's definition of disability for SSDI and SSI:

- The inability to engage in any substantial gainful activity (SGA) due to a physical or mental impairment(s) which:

1. Can be expected to result in death
   or
2. Which has lasted or can be expected to last for a continuous period of at least 12 months.

- Effective January 1, 2018 SGA amount $1,180 per month.

Ticket to Work Health Assurance Disability

Ticket to Work Health Assurance (TWHA) Medicaid category uses the same definition EXCEPT:

- Substantial Gainful Activity (SGA) does not apply to the determination;

and

- a person with a medically improved condition may qualify.

Disability Determination

- If an individual is receiving SSDI or SSI, medical information is not needed to establish the disability for MO HealthNet.
- If **not** receiving SSDI or SSI, current medical information must be submitted to the FSD Medical Review Team (MRT) for a disability determination.
  - To establish a disability based on a mental illness MRT requires a psychological evaluation signed or co-signed by psychiatrist or a licensed clinical psychologist.
  - For DMH consumers in the CPR program, the comprehensive psychosocial evaluation signed by a psychiatrist or a licensed clinical psychologist in the past 6 months is often the best psychological evaluation for MRT to use to establish the disability.

Disability Determination

If the psychosocial evaluation is not signed or co-signed by a psychiatrist or a licensed clinical psychologist OR if it is older than 6 months, it will be accepted if someone with those credentials either:

- signs a letter stating he or she has reviewed the evaluation and concurs with the findings;

or

- completes and signs the diagnosis / certification section the IM-60A (Medical Report) form, available at http://dmh.mo.gov/ada/provider/mrtpacket.html, certifying that in his or her opinion the patient has a disability.

Forms and information needed by MRT

- IM-61B - Disability Questionnaire
- IM-61C – Work History
- IM-61D - Doctor/Medical Facility List
- MO 650-2616 – “Authorization for Disclosure of Consumer Medical/Health Information” to the Department of Social Services FSD Medical Review Team

Forms and information needed by MRT

- Record of Treatment
- Evaluation by a psychiatrist or licensed clinical psychologist
- Global Assessment of Functioning (GAF)
- IM-60A – Medical Report

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

DISABILITY QUESTIONNAIRE

Save Print Reset

NAME	DOB	DATE

Pertinent Information and Observations of FSD Staff:

1. Personal Information: Age ____ Sex ____ Height ____ Weight ____
2. Highest Grade Completed: ____ GED ☐ Yes ☐ No

3a. What physical symptoms/problems do you have?

3b. What mental health symptoms/problems do you have?

Do you have crying spells or depression because of your disability? ☐ Yes ☐ No How often? ____

3c. Are your mental health symptoms due to your current circumstances (i.e. family, job, health)? ☐ Yes ☐ No

4. When did these symptoms/problems begin? ____

5. When did these symptoms first prevent you from working?

6. What are the limitations of your daily activities from this disability? Please list those you are **unable** to perform:

Able to perform?

Are you in need of caretaking? ☐ Yes ☐ No

If yes, who provides? (Check one) ☐ Nurse ☐ Relative ☐ Neighbor ☐ Friend ☐ Other: ____

7. Did you see a doctor or seek medical treatment for your symptoms? ☐ Yes ☐ No

Physician ____ How often? ____

Treatment received ____

When? ____

Physician ____ How often? ____

Treatment received ____

When? ____

8. Have you been given a specific diagnosis for your problem? ☐ Yes ☐ No What is the diagnosis? ____

9. Have you gone to Vocational Rehabilitation? ☐ Yes ☐ No (If yes, obtain VR reports and any medical examinations required by VR) What is the status of your Vocational Rehabilitation referral?

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):

	YES	NO	REFERRED	TREATED
Orthopedist	☐	☐	☐	☐
Internist	☐	☐	☐	☐
Neurologist	☐	☐	☐	☐
Cardiologist	☐	☐	☐	☐
Psychologist/Psychiatrist	☐	☐	☐	☐
Other specialist	☐	☐	☐	☐

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

ITEM NO.	

Disability Questionnaire (IM-61B)

- Fill in the client's answers to all the questions.
- Leave the pertinent information and observations of the Eligibility Specialist section blank.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

WORK HISTORY - PAST 10 YEARS

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INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

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.

EMPLOYER	TELEPHONE NUMBER

EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)

DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME
		$

JOB DESCRIPTION/DUTIES

REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP?
	☐ YES ☐ NO

EMPLOYER	TELEPHONE NUMBER

EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)

DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME
		$

JOB DESCRIPTION/DUTIES

REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP?
	☐ YES ☐ NO

EMPLOYER	TELEPHONE NUMBER

EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)

DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME
		$

JOB DESCRIPTION/DUTIES

REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP?
	☐ YES ☐ NO

EMPLOYER	TELEPHONE NUMBER

EMPLOYER'S COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)

DATES OF EMPLOYMENT: FROM (MONTH/YEAR)	TO (MONTH/YEAR)	GROSS EARNED MONTHLY INCOME
		$

JOB DESCRIPTION/DUTIES

REASON FOR LEAVING	WAS THIS THROUGH A SHELTERED WORKSHOP?
	☐ YES ☐ NO

Work History (IM-61C)

The form ask for the past 10 years work history.

- Complete the form based on information readily available from the individual, do not delay submitting the form trying to get exact information.
- If the individual doesn’t remember specific information such as phone numbers, addresses, monthly income, etc. just put an approximation based on what is remembered.
- Reason for leaving and job duties are important if the reason or it or the inability to perform the job duties are related to the individual’s medical condition.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

Save | Print | Reset

HOSPITALS, MEDICAL FACILITIES AND PHYSICIANS SEEN WITHIN THE PAST YEAR

INDIVIDUAL NAME (FIRST, MIDDLE, LAST)	INDIVIDUAL DCN	DATE OF BIRTH

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:**

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

FACILITY AND DOCTOR NAME(S)		TELEPHONE NUMBER
COMPLETE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
REASON(S) SEEN		DIAGNOSIS
LAST DATE SEEN	HOSPITALIZATION ☐ YES ☐ NO	DURATION
UPCOMING APPOINTMENTS/DATES		

Doctor/Medical Facility List (IM-61D)

The form asks the individual to list all hospitals, medical facilities, and physicians from whom he or she has received medical care in the past 12 months.

Mental health professionals, such as psychologists and licensed clinical social workers should also be included.

Save Print Reset

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:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

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 _____

MO 880-2868 (9-13)

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.

MO 880-2868 (9-13)

Authorization for Disclosure of Consumer Medical/Health Information (MO 650-2616)

- On the front:
  - Enter the client's name and date of birth;
  - Check other for who is to disclose the information;
  - Check other for who is to receive the information and enter Department of Social Services FSD Medical Review Team
  - Check eligibility determination for the purpose

- On the back the client needs to:
  - Sign #2 to authorize release of alcohol and drug abuse information

    and
  - Sign and date the form.

Record of Treatment

- The record of treatment **must be signed off on by a licensed psychologist or licensed psychiatrist**.

- The signature of a Licensed Clinical Social Worker (LCSW), even if the LCSW is the primary source of the record is insufficient.

- The physician signature must be from a psychiatrist. For mental illness, FSD will **not** accept the signature of a medical doctor who is not a psychiatrist.

Global Assessment of Functioning (GAF)

- A person with a GAF score of 50 or under is generally considered disabled by MRT.

- If the GAF score is over 50, MRT will consider other information such as the **treating psychologist or psychiatrist's opinion** as to whether or not the person is disabled, and whether the GAF is higher than 50 due to medication or treatment.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MEDICAL REPORT INCLUDING PHYSICIAN'S CERTIFICATION/DISABILITY EVALUATION

INDIVIDUAL NAME (FIRST)	(MIDDLE)	(LAST)	INDIVIDUAL SSN	DATE OF BIRTH	COUNTY

ELIGIBILITY SPECIALIST	FAMIS USER ID	LOAD	DATE OF APP/REAPP/REVIEW	DATE SUBMITTED TO MRT

TO THE EXAMINING PHYSICIAN | Physician's Name: | Specialty:

The above named person is applying for or is a member of a household which is applying for public assistance based on disability. Eligibility for assistance will be based, in part, on the medical information that you supply on this form. Therefore, please complete the entire form as thoroughly and accurately as possible. We need to know if this person has a mental or physical disability which makes him/her unable to function at his/her normal occupation or other suitable employment. After an examination has been completed and/or the medical information entered on the form, your opinion is needed about the person's mental and/or physical condition with regard to employability.

NOTE: The Family Support Division **will not** assume responsibility for payment of inpatient costs unless **prior** written authorization is given by the County Manager of the Family Support Division office that initiated this form. If you feel that hospitalization is required before you can make a decision regarding employability, indicate this on the form and return it to the Family Support Division County Office.

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

ARE YOU NOW OR HAVE YOU TREATED THIS PATIENT IN THE PAST YEAR? ☐ YES ☐ NO IF YES, DATE

BRIEF CLINICAL HISTORY (CHIEF COMPLAINTS)

HAS PATIENT BEEN HOSPITALIZED WITHIN THE PAST YEAR? ☐ NO ☐ YES IF YES, ENTER NAME OF HOSPITAL ▶ | HOSPITAL

COMPLETE FOR EACH PERSON		BLOOD PRESSURE		HGB OR HCT IF INDICATED		URINALYSIS	
WEIGHT	HEIGHT	SYSTOLIC	DIASTOLIC	HGB	HCT	SUGAR	ALBUMEN

EYES		VISION CORRECTED BY GLASSES TO		EARS HEARING (ORDINARY CONVERSATION	
RIGHT	LEFT	RIGHT	LEFT	RIGHT(20 FT.)	LEFT (20 FT.)

NOSE, THROAT, MOUTH, NECK (ABNORMALITIES)

CARDIOVASCULAR SYSTEM

CARDIAC ENLARGEMENT? ☐ YES ☐ NO	DEGREE	MURMURS	RHYTHM

EVIDENCE OF CARDIAC DECOMPENSATION ☐ YES ☐ NO BASILAR RALES ☐ YES ☐ NO LIVER ENLARGEMENT ☐ YES ☐ NO PERIPHERAL EDEMA ☐ YES ☐ NO IF YES, PLEASE EXPLAIN.

ANGINA PECTORIS? ☐ YES ☐ NO DESCRIBE PAIN AND AMOUNT OF EXERTION REQUIRED TO PRODUCE IT.

PULSE RATE	DYSPNEA	CYANOSIS	EDEMA	TYPE OF HEART DISEASE	FUNCTIONAL CLASSIFICATION

PERIPHERAL ARTERIAL DISEASE? ☐ YES ☐ NO IF YES, EXPLAIN

ABSENT PULSATION? ☐ YES ☐ NO IF YES, EXPLAIN

VARICOSITIES? ☐ YES ☐ NO IF YES, EXPLAIN

PULMONARY FUNCTION	RIGHT	LEFT

NERVOUS SYSTEM

PARALYSIS, SPEECH, GAIT, REFLEXES: PUPILLARY, KNEE, BABINSKI, ROMBERG

EVIDENCE OF ☐ PSYCHOSIS ☐ NEUROSIS ☐ MENTAL DEFICIENCY | DESCRIBE

SEIZURES ☐ NO ☐ YES IF YES, LIST ▶ | TYPE | FREQUENCY OF ATTACKS WITH MEDICATION

NEOPLASMS

SITE	BENIGN	MALIGNANT	METASTASES

BONES, JOINTS, AND EXTREMITIES

DESCRIBE DISEASE OR INJURY AND STATE LIMITATION OF MOTION, SUCH AS ABILITY TO WALK, STAND, BEND, STOOP, GRASP, ETC.

ABDOMEN

☐ SCARS ☐ TENDERNESS ☐ PALPABLY ENLARGED ORGANS ☐ HERNIA

DESCRIBE ITEMS CHECKED

GENITO-URINARY

☐ URETHRAL DISCHARGE ☐ HYDROCELE ☐ EPIDIDYMITIS ☐ PROSTATE ☐ ABNORMAL TESTICAL

DESCRIBE ITEMS CHECKED

GYNECOLOGICAL

☐ PROLAPSE ☐ CYSTOCELE ☐ RECTOCELE ☐ CERVIX ☐ ADNEXA ☐ PREGNANT EXPECTED DUE DATE

DESCRIBE ITEMS CHECKED

ANO-RECTAL

☐ HEMORRHOIDS ☐ PROLAPSE ☐ FISSURES ☐ FISTULA

DESCRIBE ITEMS CHECKED

OTHER LABORATORY FINDINGS (ATTACH WRITTEN REPORT OF X-RAYS, EKG, OR OTHER LABORATORY FINDINGS)

DIAGNOSIS (physical) : Diagnosis and GAF (Global Assessment of Funotioning): (mental health)

PRIMARY

SECONDARY

KNOWN MEDICATIONS

SUMMARIZE FINDINGS WITH EMPHASIS ON FUCTIONAL CAPACITY

IS FURTHER DIAGNOSTIC EXAMINATION INDICATED? ☐ YES ☐ NO | TYPE

DETERMINATION OF INCAPACITY: In my opinion this individual (☐ does ☐ does not have) a mental and/or physical disability which prevents him/her from engaging in that employment or gainful activity for which his/her age, training, experience or education will fit him/her. When evaluating a child, the physical or mental impairment has to compare in severity to an impairment that would make an adult disabled and evidence of marked restriction in daily age appropriate activities must exist.

DURATION OF INCAPACITY: In my opinion, the expected duration of disability/incapacity will be:

☐ 1 month ☐ 2 months ☐ 3-5 months ☐ 6-12 months ☐ 13 or more months ☐ Permanent.

THE ABOVE FINDINGS AND STATEMENTS ARE BASED ON MY EXAMINATION AND/OR RECORDS.

SIGNATURE OF PHYSICIAN (Please print physician's name beneath signature)	DATE

Medical Report (IM-60A)

- The IM-60A needs to be completed and signed by a psychiatrist or licensed clinical psychologist to certify that the client has a disability.
- At the top of the first page put the client's name, date of birth and county.
- Leave blank the individual DCN, eligibility specialist, FAMIS user ID, load, date of app., date submitted to MRT as the FSD worker will fill those in.

Medical Report (IM-60A)

- The most important parts of the form are **Diagnosis** section and the **Determination of incapacity** section.

- To be determined disabled a client needs to have a mental or physical impairment that prevents him or her from engaging in substantial gainful activity that is expected to last for more than 12 months.

Submission to MRT

Submit the forms and information to:

FSD Greene County Office
101 Park Central Square
Springfield MO 65806
Email:FSD.HOSPITALAPPLICATIONS@dss.mo.gov
Fax: 417-895-6080

Include the **RUSH** cover sheet as the first page of the packet of information submitted.

MHABD non-spend down and spend down

- Cannot be ineligible on income
- Non-spend down income limit is
  - 85% of FPL ($860/$1,166) for OAA/PTD,
  - 100% of FPL ($1,012/$1,372) for AB

MHABD Spend Down

- Monthly spend down is:
  - The amount that countable income exceeds non-spend down limit,
  - Can be paid in to MO HealthNet Division (MHD) or met with incurred medical expenses
    - If met with medical expenses, FSD determines the date met and participant's liability on that date
    - If paid to MHD in advance, there is no break in the participant's coverage

Countable Income Determination

The following income deductions are allowed:

- The first $65 of earned income
- One-half of remaining earned income
- A $20 personal income exemption
- All SSI payments
- Health insurance premiums

Spend Down example

$165	earned income
- $65	earned income exemption
$100	divided by 2 (exemption for ½ of remaining earned income)
= $50	countable earned Income
+$1,030	SSDI
- $20	personal income exemption
- $ 0	Medicare and other health ins. premiums
$1,060	countable income
-$860	income limit (85% of FPL)
$200	spend down amount

Meeting Spend Down with bills

- Spend Down amount $200
- Medical expenses sent to FSD:

3/3 Provider A	$150
3/5 Provider A	$60
3/5 Provider B	$80
TOTAL	$290

  - Spend Down is met on 3/5.
  - March coverage begins on 3/5 with a client liability of $50.
  - No claims prior to 3/5 will be paid
  - All claims 3/6 through 3/31 will be paid
  - MHD will withhold $50 from the first 3/5 claim submitted, and pay the remainder of the 3/5 claims

FSD Spend Down unit

If meeting spend down with incurred medical expenses, send to the FSD Spend Down unit by fax, scan and email, or mail:

fax 855-600-3754

email sesd@ip.sp.mo.gov

Family Support Division
16798 Oakhill Drive
Suite 600
Houston, MO., 65483

phone 855-600-4412

Ticket-to-Work Health Assurance (TWHA)

- Gross income limit is 300% of FPL ($3,035/$4,115)
- Net income limit is 85% of FPL ($860/$1,166) – same as MO HealthNet for the Disabled, but there are additional income deductions
- Premium – individual's with gross income above 100% FPL ($1,012/$1,372) must pay a monthly premium

Ticket-to-Work Health Assurance (TWHA)

- Net Income Determination
  - In addition to the income deductions for MHABD, the following are deducted in the net income determination:
    - All earned income of the disabled worker
    - A standard deduction for impairment related employment expenses equal to half the disabled workers earned income
    - $50 of SSDI
    - A $75 standard deduction for optical and dental insurance costing less than $75

Ticket-to-Work Health Assurance Premiums

Type of Case	Percent of FPL	Monthly Income	Premium Amount
Single	≤ 100% FPL	$1012.00 or less	non premium
Single	>100% FPL but < 150% FPL	$1012.01 -$1517.99	$40
Single	≥ 150% FPL but < 200% FPL	$1518.00 -$2023.99	$61
Single	≥ 200% FPL but < 250% FPL	$2024.00 -$2529.99	$101
Single	≥ 250% FPL but ≤ 300% FPL	$2530.00 - $3035.00	$152

Ticket-to-Work Health Assurance Premiums

Type of Case	Percent of FPL	Monthly Income	Premium Amount
Couple	≤ 100% FPL	$1372.00 or less	non premium
Couple	>100% FPL but < 150% FPL	$1372.01 -$2057.99	$55
Couple	≥ 150% FPL but < 200% FPL	$2058.00 -$2743.99	$82
Couple	≥ 200% FPL but < 250% FPL	$2744.00 -$3429.99	$137
Couple	≥ 250% FPL but ≤ 300% FPL	$3330.00 - $4115.00	$206

Ticket-to-Work Health Assurance (TWHA)

- SSDI recipients who go to work and continue to receive SSDI will qualify for TWHA if, without the earned income, they would:
  - be non-spend down Medicaid
    OR
    have a spend down of $50 or less
  - have a spend down above $50
    and
    are earning double the amount the spend down exceeds $50
    - (the amount of earnings needed is reduced by $150 if dental/optical insurance is purchased)

Ticket-to-Work Health Assurance (TWHA)

- *Example:*
  - If the spend down is $200,
  - The person would need a job paying $300 per month to be eligible for TWHA
    - Unless dental and optical insurance are purchased.
    - With dental and optical insurance, the person would need a job paying $150 per month.
  - The TWHA premium would be $40.
  - Available income is increased by $460 ($300 earned income + $160 difference between the spend down and the premium)

TWHA Calculator

A Ticket-to-Work Health Assurance (TWHA) calculator is available on the DMH website on:

- the **Medicaid Eligibility** page that can be accessed from the:
  - **Provider Bulletin Board** on the Mental Illness page; and
  - **Information for Providers** on the Alcohol and Drug Abuse page
- **Division of Behavioral Health Employment Services** page http://dmh.mo.gov/mentalillness/adacpsemploymentservices.html
  - It is the third item under the Work and Benefits tab.

When does coverage begin?

- Except for QMB only recipients and persons required to meet a spenddown or pay a premium, MO HealthNet coverage begins on:
  - the first day of the month of application, if eligible; or
  - up to the first day of the prior quarter, if eligible.

Medicaid Eligibility on the DMH Website

- Medicaid Eligibility Information is available on the DMH Website at www,dmh.mo.gov:

  - under “Mental Illness”
    - choose “Provider Bulletin Board”
    - choose “Medicaid Eligibility”

  - under “Alcohol & Drug Abuse”
    - choose “Information for Providers”
    - choose “Medicaid Eligibility”

Questions

Charles Bentley
Department of Mental Health
at 573-751-0342 or
email Charles.Bentley@dmh.mo.gov

Anna Leonhard
Department of Social Services
email Anna.Leonhard@dss.mo.gov or
DMH.DDMedicaidReinvestigations@dmh.mo.gov