GATEWAY TO BETTER HEALTH ELIGIBILITY REVIEW FORM

Instructions: Please read each item carefully before you answer it. The answers you give will be used to determine continued eligibility for Gateway to Better Health. You must answer each question accurately and completely in **BLACK** ink. Attach an additional sheet if more space is needed in any section.

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 Gateway to Better Health coverage.

Use the enclosed envelope to return this from by mail. You may also drop off this form at your health center.

Head of Eligibility Unit	DCN	County	
Street Address	City	State	Zip

LIST ALL MEMBERS OF THE HOUSEHOLD (List parents/guardians/yourself first. List step parents and all children who live in your home.)

Name (First, Middle, Last) (Maiden)	Hispanic Y/N	Race */ Sex	Relationship to Parent / Guardian / Self	Birthdate	Social Security Number

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

Is anyone in the household blind or disabled? ☐ Yes ☐ No If Yes, Who: _____

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

Name	Immigration Status	Registration Number	Date of Entry

HEALTH INSURANCE (other than Gateway)

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 AND EXPENSES: (**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 REC'D	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: _____

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

	Yes	**No**		**Yes**	**No**
Social Security			Union Funds or Pension Benefits		
Supplemental Security Income (SSI)			Insurance Settlements		
Alimony			Rent Received from Land/Buildings		
Money from others (friends, relatives, etc)			Room and/or Board Received		
Veteran's Benefits			Armed Forces Allotment		
	Yes	**No**		**Yes**	**No**
Worker's Compensation			Money from Sale of Property		
Unemployment Compensation			Interest from Savings/Checking Account		
Disability or Sick Benefits			Income Received from Trusts		
Income from Training Program			Income Received from Annuities		
Any other income Explain:			VA Aid and Attendance		

Has anyone recently applied for any of the above benefits? ☐ Yes ☐ No

If Yes, explain: _____

Does anyone in the household receive child support? ☐ Yes ☐ No

If Yes, complete the following and attach verification:

Amount	Per*	Name of Child

* Hour Day Week Every Two Weeks Twice Monthly Month

PLEASE READ CAREFULLY AND SIGN BELOW:

- I AGREE THAT I MUST PROVIDE Social Security Numbers for all persons receiving Gateway to Better Health 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 (10) DAYS of when they happen.
- I know 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 whatsoever, in whole or in part, may subject me to criminal and/or civil prosecution.
- I agree medical information about me and/or my family can be released if needed to administer this program.
- Provided I am found to be eligible for Gateway to Better Health, 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.

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 website 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.

Signature/Affidavit/Mark	**Date**	**Signature/Affidavit/Mark**	**Date**

Please remember to:

1. **Sign this form. Forms without signature will not be accepted.**
2. **Include proof of income such as paystubs, tax return, social security statement, etc., for the last 30 days**