

**MISSOURI FAMILY SUPPORT DIVISION
REVIEW – ELIGIBILITY STATEMENT**

IM-2D
(Rev. 9/09)

A. Case (1) _____ Case (1) _____ Elig. Specialist _____ Application
 Name (2) _____ No(s) (2) _____ Load No. _____ Reinvestigation
 Date _____ OV HV Other _____ State Hospital IMR SP (OAA PTD AB) MHABD SNC SAB BP

THE FAMILY SUPPORT DIVISION IS REQUIRED TO REVIEW THE ELIGIBILITY OF PERSONS RECEIVING ASSISTANCE AT LEAST ONCE A YEAR. IN ORDER TO DETERMINE ELIGIBILITY WE ARE ASKING THAT YOU COMPLETE ALL SECTIONS OF THIS FORM. IF IT WAS MAILED TO YOU, RETURN IT IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.

B. ADDRESS _____
 YOUR TELEPHONE NUMBER _____ TELEPHONE NUMBER WHERE YOU MAY BE REACHED _____

C. FOOD STAMPS	COUNTY USE ONLY
I wish to participate in the Food Stamp Program. Yes <input type="checkbox"/> No <input type="checkbox"/> If no, explain _____ _____	FOOD STAMP ELIGIBILITY <input type="checkbox"/> Application taken <input type="checkbox"/> Application not taken <input type="checkbox"/> Active case

D. CITIZENSHIP AND RESIDENCY	CITIZENSHIP/RESIDENCY
I/We are United States citizens. Yes <input type="checkbox"/> No <input type="checkbox"/> If no, are you a legal alien? Yes <input type="checkbox"/> No <input type="checkbox"/> If an alien, list current immigration status and alien registration number _____ I/We are residents of Missouri and intend to remain in Missouri. Yes <input type="checkbox"/> No <input type="checkbox"/>	Citizen Yes <input type="checkbox"/> No <input type="checkbox"/> Legal Alien Yes <input type="checkbox"/> No <input type="checkbox"/> Identity verified <input type="checkbox"/> No <input type="checkbox"/> What verification used? Intends to remain in Missouri: Yes <input type="checkbox"/> No <input type="checkbox"/>

E. LIST ALL OF THE PERSONS WHO LIVE IN YOUR HOME (List your name first)	AGE VERIFICATION																																																								
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">NAME (FIRST, MIDDLE, LAST)</th> <th style="width:10%;">RACE/ SEX</th> <th style="width:15%;">RELATIONSHIP (son, sister, friend)</th> <th style="width:10%;">BIRTHDATE</th> <th style="width:10%;">PLACE OF BIRTH</th> <th style="width:15%;">SOCIAL SECURITY ACCOUNT NUMBER</th> <th style="width:15%;">SOCIAL SECURITY CLAIM NUMBER</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	NAME (FIRST, MIDDLE, LAST)	RACE/ SEX	RELATIONSHIP (son, sister, friend)	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY ACCOUNT NUMBER	SOCIAL SECURITY CLAIM NUMBER																																																		IM-36 complete <input type="checkbox"/> Narrative - Page No. _____ Explain Obvious Eligibility: INSURANCE NA <input type="checkbox"/> IM-9 or policy IM-37 Completed/Reviewed/Updated: Date: _____ TPL-1 sent Date: _____
NAME (FIRST, MIDDLE, LAST)	RACE/ SEX	RELATIONSHIP (son, sister, friend)	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY ACCOUNT NUMBER	SOCIAL SECURITY CLAIM NUMBER																																																			

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LIST PERSON INSURED	NAME OF COMPANY	KIND OF INSURANCE	POLICY NUMBER	FACE VALUE	PREMIUM AMOUNT PAID	HOW OFTEN	PAID BY WHOM																																											

G. CASH AND SECURITIES – PERSONAL PROPERTY:										COUNTY USE ONLY	
1. I/We have the following cash, securities, or personal property	YES	NO	IN WHOSE NAME	LOCATION	VALUE						CASH AND SECURITIES NA <input type="checkbox"/>
a. Checking account/joint checking accounts Account numbers:	<input type="checkbox"/>	<input type="checkbox"/>									IM-7 Received Date _____ (Filed in case record.) Record any other verification used.
b. Savings accounts, joint savings accounts, Christmas club savings, Time Certificates of Deposits in Credit Union. Account numbers:	<input type="checkbox"/>	<input type="checkbox"/>									PERSONAL PROPERTY
c. Patient accounts at a nursing home or other institution.	<input type="checkbox"/>	<input type="checkbox"/>									
d. Savings or cash at home, on my person, or being held by someone else.	<input type="checkbox"/>	<input type="checkbox"/>									
e. Stocks, bonds, or other investments. If yes, how many?	<input type="checkbox"/>	<input type="checkbox"/>									
f. Notes or mortgages owed to you	<input type="checkbox"/>	<input type="checkbox"/>									
g. Trust funds	<input type="checkbox"/>	<input type="checkbox"/>									
h. Property held in Safe Deposit Box (State location and contents of box)	<input type="checkbox"/>	<input type="checkbox"/>									
			LOCATION	VALUE	DEBT						REAL PROPERTY NA <input type="checkbox"/>
i. Household furniture (in use)	<input type="checkbox"/>	<input type="checkbox"/>									IM-8 Rec'd. Date _____ (Filed in case record.) Record any other verification used: (IM-43, IM-43A, Other.)
j. Household furniture (not in use)	<input type="checkbox"/>	<input type="checkbox"/>									
k. House trailer (Mobile home)	<input type="checkbox"/>	<input type="checkbox"/>									
l. Jewelry (other than wedding and engagement rings, watches or costume jewelry)	<input type="checkbox"/>	<input type="checkbox"/>									
m. Business equipment	<input type="checkbox"/>	<input type="checkbox"/>									
n. Farm machinery	<input type="checkbox"/>	<input type="checkbox"/>									
o. Farm grain and produce	<input type="checkbox"/>	<input type="checkbox"/>									
p. Farm livestock	<input type="checkbox"/>	<input type="checkbox"/>									
q. Property claims in Probate Court	<input type="checkbox"/>	<input type="checkbox"/>									
r. Other (Explain)	<input type="checkbox"/>	<input type="checkbox"/>									
										TOTAL PROPERTY \$ _____	
s. Vehicles	MAKE	YEAR	OWNER	IS IT LICENSED?	VALUE	DEBT	HOW USED				(Total of F, G, H)
											TOTAL AVAILABLE RESOURCES
										Cash Surrender Value (CSV) (F) \$ _____	
										Cash and Securities (G) a – h) \$ _____	
										Available Personal Property (G) i – s) \$ _____	
										Available Real Property (H) \$ _____	
										TOTAL \$ _____	
H. REAL PROPERTY											
I/We own or are buying real estate. Yes <input type="checkbox"/> No <input type="checkbox"/>											
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	
										Consider time limitations, verify, and record eligibility.	
I. TRANSFER OF PROPERTY OR RESOURCES											
Has anyone in your home sold or given away any money, vehicles, property, or any other resources? Yes <input type="checkbox"/> No <input type="checkbox"/>											
If yes, complete the following:											
What? _____											
When? _____											
To Whom? _____											
Why? _____ Amount Received: \$ _____											

J. INCOME							COUNTY USE ONLY			
Have you or your spouse ever served in the U.S. Military? Yes <input type="checkbox"/> No <input type="checkbox"/> I am/We are employed. Yes <input type="checkbox"/> No <input type="checkbox"/> Where? _____ Amount you are paid before deductions? \$ _____ How often? _____							EMPLOYMENT/INCOME Wage information: IM-12, Wage Stubs, E.S. Printout, other. All verification and recording of income and expenses must be done on the appropriate budget (IM-30, IM-30A, IM-30B).			
I/We receive income from:	Yes	No	Amount		Yes	No	Amount	UNEARNED INCOME Possible sources of verification: IM-7, IM-12, IM-13, IM-41, IM-76, Printout, Checks, Case Record, Other. Explore potential eligibility for OASI/RSDI/VA, explain if necessary:		
Self-Employment	<input type="checkbox"/>	<input type="checkbox"/>	\$	Unemployment Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$			
Property Rental	<input type="checkbox"/>	<input type="checkbox"/>	\$	Assistance from friends or relatives	<input type="checkbox"/>	<input type="checkbox"/>	\$			
Child Support Payments	<input type="checkbox"/>	<input type="checkbox"/>	\$	Assistance or food stamps from another state	<input type="checkbox"/>	<input type="checkbox"/>	\$			
Interest or Dividends	<input type="checkbox"/>	<input type="checkbox"/>	\$	Other:	<input type="checkbox"/>	<input type="checkbox"/>	\$			
Social Security (Retirement)	<input type="checkbox"/>	<input type="checkbox"/>	\$	(Explain below where the money comes from and the amount.)						
SSI Benefits (from Social Security)	<input type="checkbox"/>	<input type="checkbox"/>	\$							
Veterans Benefits	<input type="checkbox"/>	<input type="checkbox"/>	\$							
Railroad Retirement	<input type="checkbox"/>	<input type="checkbox"/>	\$							
Armed Forces Allotments	<input type="checkbox"/>	<input type="checkbox"/>	\$							
K. COLLATERAL INFORMATION							COLLATERAL Identify collateral, date contacted, qualifications, and information received.			
Please provide the names of two persons who live outside of your home and are not related to you, who can verify your statements.										
NAME				NAME						
ADDRESS				ADDRESS						
TELEPHONE NUMBER				TELEPHONE NUMBER						
THIS PERSON IS ABLE TO VERIFY MY STATEMENTS BECAUSE				THIS PERSON IS ABLE TO VERIFY MY STATEMENTS BECAUSE						
L. SUPPLEMENTAL AID TO THE BLIND OR BLIND PENSION							SAB-BP IM-2B: Date: _____ Parent or sighted spouse able to support: NA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			
1. Do you have a sighted spouse or parent? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Do you solicit alms? Yes <input type="checkbox"/> No <input type="checkbox"/>										
M. IF RECEIVING BLIND PENSION, COMPLETE THIS SECTION										
1. Have you had eye surgery since the last review? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. If you are under age 75, are you willing to have medical treatment or an operation to correct blindness? Yes <input type="checkbox"/> No <input type="checkbox"/> 3. If recommended, are you willing to accept vocational training or work at an occupation for which you are suited? Yes <input type="checkbox"/> No <input type="checkbox"/> 4. Are you living in or supported by a public, medical, or private institution? Yes <input type="checkbox"/> No <input type="checkbox"/>							BP Only IM-2A: Date: _____ SSI/RRB (IM-76, SDX) NA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If no, explain:			
N. NO HEALTHNET FOR THE AGED, BLIND, AND DISABLED OR SUPPLEMENTAL NURSING CARE										
1. Do you live in or plan to enter a nursing home? Yes <input type="checkbox"/> No <input type="checkbox"/>										

NOTE: If you were approved for assistance based on disability requirements, you may be required to furnish new medical information to determine your continued eligibility. If an IM-60 or IM-60A is attached, please sign them and return them with this form. List the doctor(s) you wish contacted to provide a full and accurate statement of your medical history and condition.

Doctor's name _____ Address _____

Doctor's name _____ Address _____

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 and 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 of any change in address.

This is to certify under penalty of perjury that the foregoing 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 (\$1,000); or by both, where an act or series of acts a person defrauds the state of one hundred fifty dollars (\$150) 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 services 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 that 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 person's 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.

This is to certify that I/we understand the questions on this form and the penalties for giving false statements or withholding information about any individual for whom I am/we are am applying for or receiving assistance. Under the penalty of perjury, I/we certify that I/we have given true, accurate, and complete statements to the best of my/our knowledge.

SIGNATURE OR MARK/AFFIDAVIT _____ (DATE) _____

SIGNATURE OF SPOUSE/AFFIDAVIT _____ (DATE) _____

ELIGIBILITY SPECIALIST SIGNATURE _____

COUNTY USE ONLY – DO NOT WRITE BELOW

Relative/Payee Name _____	PHONE NUMBER _____
Address _____	

COUNTY USE ONLY

INCAPACITY (IM-60, IM-60A, IM-61)
 NA PTD AB SAB BP
 Disability established Yes No
 Decision MRT Local SSA/SSI State Ophthalmologist

Decision Date (1) _____ (2) _____

Re-exam Date (1) _____ (2) _____

Waived (1) _____ (2) _____

INSTITUTIONAL RESIDENCE (DA-124, IM-71)
 Name of Institution _____
 DA-124 Dated _____
 Level of Care _____

VR TREATMENT NA YES
 Date of Referral _____
 MRT applied eligibility factors: YES NO

DECISION
SAB/AB/SP Option: IM-30 Date _____
MHABD: IM-30A Date _____
MHC/IMR/SP/SNC: IM-30B Date _____

Eligible
 Rejection Reason: _____
 Closing Reason: _____
 Decision Date _____

Prior Quarter Coverage Yes No If no, explain: _____

Priority Yes No

SERVICES

B-2	Yes <input type="checkbox"/> No <input type="checkbox"/>
IM-50	Yes <input type="checkbox"/> No <input type="checkbox"/>
IM-54	Yes <input type="checkbox"/> No <input type="checkbox"/>