



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 FAMILY SUPPORT DIVISION
ELIGIBILITY REINVESTIGATION

COMPLETE AND RETURN BY

INSTRUCTIONS: Please read each item carefully before you answer it. The answer you give will be used to determine if you are eligible to continue to receive financial and/or medical help. A friend or relative may help you. If you need any assistance in completing or understanding any part of the form, please ask your Eligibility Specialist. You must answer each question accurately and completely. You may be required to provide verification of your statements. **THIS FORM MUST BE COMPLETED IN INK.**

A. ADDRESS AND TELEPHONE NUMBER		NAME	DCN	CASELOAD NUMBER
CURRENT ADDRESS (STREET, CITY, STATE, ZIP CODE)			OFFICE VISIT	MAILED OUT

CURRENT TELEPHONE NUMBER	LIST ANY OTHER TELEPHONE NUMBER(S) WHERE YOU MAY BE REACHED
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DO NOT WRITE IN THE GRAY AREA

REFERENCE STATEMENT: Include name, address, phone no., date contacted, qualifications, and information received.

DEPRIVED OF PARENTAL SUPPORT VERIFICATION: See reference statement
 Other, explain below:

DCSE COOPERATION NOT IN QUESTION:

INCAPACITY: Established by MRT Local
 Decision date _____ Re-exam date _____

Is the IM-36 completed? YES NO

SCHOOL ATTENDANCE: N/A Verified

CASE MANAGEMENT – Status Determined

CITIZENSHIP: If alien, verify current immigration status

SOCIAL SECURITY NUMBER:
 All persons receiving Temporary Assistance have Social Security Numbers: YES NO
 If no, enter date of referral and on whom: _____

B. LIST ALL OF THE MEMBERS OF THE HOUSEHOLD

NAME (LAST, FIRST, MIDDLE) (MAIDEN)	DATE OF BIRTH	PLACE OF BIRTH	U.S. CITIZEN Y/N	HIGHEST GRADE COMPLETED	NAME OF SCHOOL CURRENTLY ATTENDING

IF YOU HAVE ADDITIONAL HOUSEHOLD MEMBERS, LIST THEM ON A SEPARATE PIECE OF PAPER AND RETURN IT WITH THIS FORM TO YOUR ELIGIBILITY SPECIALIST.

1. Are both parents of any of the children in the home? YES NO
 If yes, please explain.

2. If there is a step-parent in your household, do they pay child support or alimony? YES NO
 If yes, please explain.

3. Do you have any new information about the absent parent(s)? YES NO
 If yes, please give details.

C. VERIFYING STATEMENTS

NAME	NAME
ADDRESS	ADDRESS
TELEPHONE NUMBER	TELEPHONE NUMBER

D. EMPLOYMENT

1A. Have you or your spouse ever served in the U.S. Military? YES NO
 1B. Is anyone in the household employed? YES NO If yes, complete the following:

NAME OF PERSON WITH JOB		EMPLOYER NAME			DATE RECEIVED	DATE OF CHECK	NO. OF HOURS	AMT. EARNED BEFORE DEDUCTIONS	TIPS OR COMMISSIONS
RATE OF PAY \$		PER	EMPLOYER PHONE NUMBER						
DATE RECEIVED	DATE OF CHECK	NO. OF HOURS	AMT. EARNED BEFORE DEDUCTIONS	TIPS OR COMMISSIONS					

ATTACH COPIES OF WAGE STUBS FROM LAST TWO FULL MONTHS TO THIS FORM. IF WAGE STUBS ARE NOT AVAILABLE, ATTACH LETTER FROM EMPLOYER VERIFYING THE ABOVE. IF SOMEONE ELSE IS EMPLOYED, LIST THE SAME INFORMATION ON A SEPARATE PIECE OF PAPER AND ATTACH HIS/HER WAGE STUBS.

2. Do you anticipate any change in employer, hours worked, or wages paid? YES NO
 3. Have you worked within the last 12 months? YES NO If yes, how many months employed? ▶
 4. Is there anyone who plans to go to work? YES NO If yes, who and when?
 5. Is anyone self-employed? YES NO If yes, list who and explain.

E. CHILD CARE

Does your household have expenses for child care or for care of an ill or disabled person? YES NO
 If yes, complete below and attach verification.

NAME OF PERSON RECEIVING CARE	WHO PROVIDES CARE? (NAME, ADDRESS AND TELEPHONE NUMBER)	DATES PAID	AMOUNT PAID

F. UNEARNED INCOME

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

	YES	NO		YES	NO
Social Security			Union Fund or Pension Benefits		
Supplemental Security Income (SSI)			Insurance Settlements		
Alimony or child support			Rent received from land/buildings		
Money from others, such as friends and relatives			Room and/or board received		
Veteran's benefits			Armed Forces allotment		
Workers' Compensation			Money from sale of property		
Unemployment Compensation			Interest from savings accounts & checking accounts		
Disability or sick benefits			Any other income		
Income from training program(s)			Explain:		

Have you recently applied for any of the above benefits? YES NO If yes, list:

COUNTY USE ONLY

IM-30 dated _____

POTENTIAL ELIGIBILITY FOR RSDI/WA/UC, ETC.
EXPLORED: YES NO
QMB: YES NO
 Use of benefits not in question:

PRIORITY: YES NO
 Date(s):
 Reasons:

G. RESOURCES:

This section applies to all persons, including children, for whom you are applying or receiving benefits. Include the spouse, parent or step-parent (if living in the home) of any person for whom you are applying for or receiving benefits.

1. I/We have the following cash and securities	YES	NO	IN WHOSE NAME?	LOCATION	VALUE
a. Checking Account Account Numbers:					
b. Savings Accounts, Certificates of Deposit Account Numbers:					
c. Savings at home, on my person, or being held by someone else					
d. Stocks, bonds, or other investments. If yes, how many?					
e. Notes or mortgages owed to you (Does anyone owe you money?)					
f. Trust funds					
g. Property held in Safe Deposit Box (State location and contents)					

2. I/We have the following personal property:	YES	NO	LOCATION	VALUE	DEBT
a. Household Furniture (not in use)					
b. Housetrailer (mobile home)					
c. Jewelry (other than wedding and engagement rings, watches or costume jewelry)					
d. Business equipment					
e. Farm machinery					
f. Farm grain and produce					
g. Farm livestock					
h. Other (list):					

i. List any vehicles your household owns or is buying. (Includes cars, trucks, vans, motorcycles, boats, recreational vehicles, tractors, others).

MAKE	MODEL	YEAR	OWNER	LICENSED? Y/N	VALUE	DEBT	HOW IS VEHICLE USED?

3. I/We are buying or own 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? (HOME RENTAL)

4. I/We have life, medical, hospital insurance, Medicare, or prepaid burial plans. YES NO List policies below:

PERSON INSURED	NAME OF COMPANY AND POLICY NUMBER	PERSON INSURED	NAME OF COMPANY AND POLICY NUMBER

H. SERVICES

If you are pregnant or a nursing mother, or have infants or children under the age of five, you may be eligible for the WIC program. It can provide you with free infant formula, eggs, milk, cheese, and help you to plan healthy meals for you and your family. I am interested in this program. YES NO

I am pregnant and would like a health risk appraisal and case management services. YES NO

I would like information about family planning. YES NO

COUNTY USE ONLY

CASH AND SECURITIES: NA
 IM-7 Rec'd. _____ DATE Filed in Record

PERSONAL PROPERTY: NA

REAL ESTATE: NA

VEHICLES: NA NADA Blue Book

INSURANCE: NA
 IM-9 or Policy
 IM-37 Completed/Reviewed/Updated _____ DATE
 TPL-1 Completed/Updated & Sent _____ DATE

RESOURCES CONSIDERED \$ _____

SERVICE REFERRALS: Considered or Made

READ CAREFULLY AND SIGN THIS PAGE

I/WE FURTHER AUTHORIZE THE DEPARTMENT OF SOCIAL SERVICES THROUGH THE DIRECTOR OF FAMILY SUPPORT DIVISION OR HIS APPOINTEE TO MAKE AN INVESTIGATION OF THESE CIRCUMSTANCES AND STATEMENTS.

I/WE UNDERSTAND that the authorization and approval to receive these benefits is based on the statements and declarations made by me/us in this Eligibility Statement which I/we declare are true, accurate, and complete.

I/WE UNDERSTAND that I/we must provide Social Security Numbers (SSN) for myself and all persons who are applying for or receiving Temporary Assistance and/or Medicaid as a condition of eligibility. The SSN will be used to determine eligibility and the level of benefits, verify information, prevent duplicate participation, and to 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 UNDERSTAND that I/we must personally notify my/our Eligibility Specialist, or his or her supervisor of any changes in circumstances as declared in the Eligibility Statement, no matter what the source of those changed circumstances.

I/WE UNDERSTAND that I/we must report these changes in circumstances within TEN DAYS, that I/we have a continuing obligation to report these changes in circumstances within TEN DAYS of when they happen, and that I/we cannot wait until I am/we are contacted by my/our eligibility specialist to report these changes.

I/WE UNDERSTAND that it is against the law to obtain public assistance benefits to which I am/we are not entitled or to obtain public assistance benefits in an amount greater than those to which I am/we are entitled in the Temporary Assistance Program.

I/WE UNDERSTAND that any false claim, statement, or concealment of any material fact whatever, in whole or in part, may subject me/us to criminal and/or civil prosecution under the laws of the State of Missouri and/or the United States.

I/WE UNDERSTAND that I/we must cooperate with the Department of Social Services, the Family Support Division staff, and Quality Control if my/our case is selected for review.

I/WE UNDERSTAND that if I/we apply for or are recipients of Temporary Assistance from the Family Support Division, I/we by applying for Temporary Assistance, have assigned any and all vested, existing rights to medical support, and the rights to receive support payments which are past due, currently due, or which will become due in the future to which I am/we are entitled in my/our own behalf or in behalf of the child or children for whom I am/we are applying for or receiving assistance payments to the State of Missouri. This assignment shall take effect upon a determination of eligibility for Temporary Assistance and shall remain in full force and effect so long as I am/we are recipients of Temporary Assistance. Upon the termination of my/our receipt of Temporary Assistance payments, this assignment shall remain in effect as to the unpaid support obligations owing at the time of the discontinuance of Temporary Assistance.

I/WE UNDERSTAND that by applying for (and being determined eligible for) medical assistance for a child who is deprived of parental support, I/we have assigned any and all vested existing rights to medical support to the State of Missouri, and that I/we must cooperate in obtaining the medical support. Such cooperation may involve identifying the absent parent, helping locate the absent parent, helping to establish paternity, and other necessary action as needed to obtain this medical support.

THE ELIGIBILITY SPECIALIST HELPED ME/US BY COMPLETING PARTS OF THIS FORM. <input type="checkbox"/> YES <input type="checkbox"/> NO		MY/OUR SIGNATURE BELOW CERTIFIES UNDER PENALTY OF PERJURY THAT ALL DECLARATIONS MADE BY ME/US IN THIS REINVESTIGATION ARE TRUE, ACCURATE, AND COMPLETE.	
DID ANYONE HELP YOU COMPLETE THIS FORM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ENTER HIS/HER NAME(S).		PARTICIPANT SIGNATURE X	DATE
WITNESS (IF MARKED WITH X)	WITNESS (IF MARKED WITH X)	SPOUSE'S SIGNATURE (IF LIVING WITH YOU) X	DATE