



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 MO HEALTHNET DIVISION  
 SPENDDOWN PAY-IN  
 AUTOMATIC WITHDRAWAL AUTHORIZATION  
 (START, CHANGE OR CANCEL)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please allow 30 days for automatic withdrawal to start/change/cancel.** When the automatic withdrawal is effective you will not receive a monthly invoice. Continue to pay the monthly invoices you receive until then. The automatic withdrawal is taken out of your account for the following month; example, June is taken out for July, etc. If you need help filling out the Automatic Withdrawal form, or to verify the effective date, call toll free at 1-877-888-2811.

- Start I want the Missouri Department of Social Services to withdraw the Spenddown Pay-In from my account.
- Change I want the Missouri Department of Social Services to change automatic withdrawal to the bank account named below.
- Cancel I want to cancel the automatic withdrawal of the Spenddown Pay-In.

**PART A - Account Information**

Checking  Savings

**IMPORTANT:**

Attach a voided personal check, savings deposit slip or a signed bank verification letter to the application form. Your name must be pre-printed on the check or savings deposit slip; starter, counter checks or bank statements are not acceptable. A bank verification letter must be signed by the bank and include your name as well as complete electronic routing and depositor account numbers. The bank verification letter must state it is for automatic withdrawal – not for a direct deposit.

**PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION**

Name of Financial Institution \_\_\_\_\_

Address of Financial Institution (Street) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

Financial Institution Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

---

**Part B- Agreement**

I hereby authorize the withdrawal of the spenddown pay-in on or around the **10th** of each month from my checking or savings account with the financial institution indicated above. The automatic withdrawal is taken out of your account for the following month; example, June is taken out for July, etc. I understand that the spenddown pay-in amount will vary monthly based on family size and income, and authorize continued automatic withdrawals. Withdrawals will be made monthly unless I choose to terminate this agreement. I understand that the MO HealthNet Division will make a reasonable effort to complete this transaction in a timely manner. I recognize that it is my responsibility to have the funds available in the account indicated above for the withdrawal of my monthly spenddown pay-in.

Signature of Bank Account Holder \_\_\_\_\_ Date \_\_\_\_\_

Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

---

**Part C- Customer Information**

**Case Number** \_\_\_\_\_

Name \_\_\_\_\_

Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Date \_\_\_\_\_

Signature of Case Head \_\_\_\_\_

**Mail both pages of the Automatic Withdrawal Authorization form and your voided personal check or savings deposit slip or signed bank verification letter to: MO HealthNet Division, Financial Services Unit, P.O. Box 6500, Jefferson City, MO 65102-6500.**