

Special Health Services (SHS) - Annual Financial Eligibility Review (AFER) Form

Check the appropriate box to determine financial eligibility:

- Federal Income Tax Form filed for 2015 and a copy is attached.
Is the income filed in 2015 reflective of the current income status? If not, please provide explanation on separate letter to Service Coordinator and attach a copy of the tax form.
- Not required to file 2015 taxes.
- Request for Extension Form filed for 2015 and a written estimate of income is attached.
- Have applied for an Individual Tax Identification Number (ITIN).
- No longer interested in receiving SHS Services.

Verify the following information on file. If information is incorrect, please provide the correct information.

Information on file:

Correct information:

Participant Name

DCN

Date of Birth

Telephone Number

Street Address

City, State, Zip

County

Responsible Party Name

Responsible Party Telephone

Responsible Party Address

Responsible City, State, Zip

Alternate Contact(s) Name

Alternate Contact Telephone

Alternate Contact(s) Name

Alternate Contact Telephone

Alternate Contact(s) Name

Alternate Contact Telephone

Insurance

Insurance

Insurance

MO HealthNet

Other Household members enrolled in a SHS Program.

YES NO

PARTICIPANT/RESPONSIBLE PARTY RIGHTS AND RESPONSIBILITIES:

Application is made for admission of the above name participant to Special Health Services. I authorize SHS to release or obtain information to or from any agencies which are participating in the treatment and care plan for the applicant. The information on this application form may be exchanged with agencies that administer relevant or applicable programs. I consent to the release of personal, financial, and medical information from this application form and supporting documents to the agencies that administer relevant or applicable programs for establishing and verifying eligibility and for performing evaluations. I understand that the agencies that administer such programs will maintain confidentiality of this information according to applicable laws. I have been informed that SHS provides care on a nondiscriminatory basis as required by Title VI of the Civil Rights Act of 1964. I understand SHS eligibility will not be considered until all information has been received by SHS. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in repaying in cash the value of benefits received. I understand any medical insurance benefits I may receive for services authorized by SHS may be forwarded to the provider of service(s). I must cooperate with the providers of services and SHS in giving all information concerning trust funds, legal actions, settlements and third party payors i.e., medical insurance, MO HealthNet, etc. I have been advised and understand my rights and responsibilities under SHS. All the information I have provided is correct to the best of my knowledge.

Signature of Participant 18 or Older	Signature of Parent/Guardian	Date of Signature
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