MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

BCCT MEDICAL ASSISTANCE APPLICATION

BCCCP PROVIDER
TELEPHONE NUMBER
DIAGNOSIS DATE

Send completed application to:
Family Support Division
PO Box 2320
Jefferson City MO 65102-2320
FAX: 573-751-3091

FOR OFFICE USE ONLY		
DATE APPLIED		
DCN		
SERVICE REP	SUPERVISOR	LOAD

COMPLETE IN INK

A. MAILING ADDRESS

NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RACE/ETHNIC

ADDRESS (HOUSE NO., STREET, RURAL ROUTE, PO BOX NO) CITY, STATE, ZIP CODE COUNTY

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE PHONE NUMBER

B. INSTRUCTIONS: Please answer each question completely.

	YES	NO
1. Are you a U.S. citizen? If **"NO"**, list immigration status and registration number, date of entry:	☐	☐
2. Do you currently have healthcare insurance?	☐	☐

NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
	☐ DOCTOR ☐ HOSPITAL **If limited coverage explain:**

	YES	NO
3. Do you have children under the age of 19 residing in your home?	☐	☐
4. Are you pregnant?	☐	☐
5. Are you blind?	☐	☐
6. Are you disabled?	☐	☐

C. PLEASE READ CAREFULLY AND SIGN BELOW:

- I agree to provide Social Security Numbers of all persons applying for Medicaid 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 DAYS** of when they happen.
- I know that it is against the law 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 that medical information about me can be released if needed to administer this program.
- I understand Healthcare benefits based on a person being blind, disabled, age 65 or over, pregnant women, child or parent, is not determined by completing this application. If I want eligibility for healthcare benefits explored on the basis of one of these, I must complete a different application for these benefits.
- Provided I am found to be eligible for Medicaid, 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.
- I understand the decision on my eligibility will be released to the State of Missouri BCCCP Program for tracking purposes.
- I understand that if I disagree with the decision concerning my eligibility, I may request a fair hearing within 90 days of the date of the decision.
- I understand I am entitled to fair and equal treatment regardless of my age, sex, race, color, handicap, religion, creed, national origin or political belief.

I agree that the 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	DATE

CALL 888-275-5908 IF YOU HAVE ANY QUESTIONS.