

Child name _____ DOB ____ / ____ / ____ HOH _____

ATTACHMENT D

Family Statement of Medicaid Eligibility

I/WE the undersigned understand that if the First Steps eligible child indicated on this form is Medicaid eligible, this family/household is automatically exempt from paying the monthly participation fee as required by Sections 160.900- 160.925, RSMo., regardless of whether or not this family otherwise meets the criteria to pay a monthly fee.

I/WE further understand that by signing this document, we certify, that to the best of our knowledge, the named First Steps child **is eligible for Medicaid.**

I/WE further understand that this eligibility cannot be determined with accuracy until the child's data can be verified by the CFO/Medicaid verification submission and that the final determination of a monthly fee amount will automatically be calculated based on other family financial information I have provided in the event this child is **not determined to be eligible for Medicaid.**

I/WE understand that this form cannot be utilized/signed UNTIL I/WE sign a "Consent to Release Medicaid Information".

Childs Name (Print) _____ Medicaid Number _____

Head of Household Name (Print) _____

Head of Household (Signature) _____ Date Signed _____

Service Coordinator (Signature) _____ Date Signed _____

Distribution:

Original to Child File

Copy to Family