Camden County Developmental Disability Resources

Medicaid Spenddown, Ticket-to-Work, and Other Medicaid Premium Assistance Program Agreement

100 3rd Street PO Box 722 Camdenton, MO 65020

Phone: (573) 317-9233 Fax (573) 317-9332

First Anticipated Payment Date: _____

Payment Amount (subject to change): _____

Name (Payments on behalf of): _____

Address: _____

Date of Birth: _____

DMH ID #: _____

Camden County Developmental Disability Resources (CCDDR) has determined that you/your household member is eligible to receive assistance in paying your/your household member's monthly Medicaid spenddown, Ticket-to-Work premium, or other Medicaid premium. You/your household member must provide the monthly invoice to CCDDR. CCDDR will submit payment directly to MO Healthnet on your/your household member's behalf.

If the Medicaid spenddown, Ticket-to-Work premium, or other Medicaid premium changes; the household income changes; or the household composition changes; the household is required to notify CCDDR immediately. CCDDR reserves the right to discontinue this support at any time due to, but not limited to, changes in your monthly invoice amount, changes in the household income, changes to the policy, changes in available funding, and/or failure to comply with the assistance program's requirements.

Occasionally, your/your household member's monthly amount will be adjusted. Any retroactive adjustments made in your favor will be sent to you via a check from the State of Missouri. If you/your household member receives a check for retroactive adjustments reflecting an overpayment for the Medicaid spenddown, Ticket-to-Work premium, or other Medicaid premium, you are to ***notify CCDDR immediately***. **This is a refund of funds paid by CCDDR on your/your household member's behalf and should be reimbursed to CCDDR. Do not cash this check until a copy of the check is provided to CCDDR. CCDDR staff will provide you/your family member with the information on how to return the funds to CCDDR.**

I/we wish to participate in the Medicaid Spenddown, Ticket-to-Work Premium, and Other Medicaid Premium Assistance Program. I/we hereby acknowledge all rules and conditions as set forth in this Agreement and in the Medicaid Spenddown, Ticket-to-Work Premium, and Other Medicaid Premium Assistance Program Guidelines. Any falsified or undisclosed information may result in disqualification from program participation, repayment by the household for applicable assistance payments made on behalf of the individual(s), and/or civil/criminal action being filed.

(All household members 18 years-of-age or older and/or guardian(s) must sign)

Household Member Signature	Date	Household Member Signature	Date
Household Member Signature	Date	Household Member Signature	Date
Household Member Signature	Date	Household Member Signature	Date
Guardian/Power of Attorney Signature	Date	Guardian/Power of Attorney Signature	Date