Missouri Department of SOCIAL SERVICES
Your Potential. Our Support.

Supplemental Form for MO HealthNet for Families Programs

STEP 1 Fill in the information for the main contact person

(We need one adult in the family to be the contact person for your application supplement.)

1. LEGAL NAME (First Name, Middle name, Last Name, & Suffix)

2. Home address (Leave blank if you do not have one.) 3. Apartment or suite number

4. City 5. State 6. ZIP code 7. County

8. ☐ Check here if your mailing address is the same as your home address. **If it is not the same**, you must give us your mailing address below:

9. ☐ Check here if the mailing address provided is a Safe at Home address. Safe at Home authorization code _____

10. Mailing Address 11. Apartment or suite number

12. City 13. State 14. ZIP Code 15. County of residence

16. Phone number ( ) 17. Other phone number and type (message, work, cell) ( )

18. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address:

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage for future years, I agree to allow the Family Support Division to use income data, including information from tax returns. The Family Support Division will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Do not use information from tax returns to renew my coverage.

STEP 2 Tell us about the household

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You do not need to file taxes to get health coverage).

DO Include:

- Yourself (Applicant)
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- The parent of any child who needs health coverage
- Anyone you include on your tax return, even if they do not live with you
- Anyone else under 21 who you take care of and lives with you

You DO NOT have to include:

- Your unmarried partner who does not need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you are over 21)
- Other adult relatives who file their own tax return

Complete Step 2 for your household.

- We will keep all the information you provide private and secure as required by law. We will use personal information only to check if you are eligible for health coverage. You do not need to provide immigration status or a Social Security Number (SSN) for family members who do not need health coverage.

STEP 2: Tax-Filing & Household Information

Do you plan to file a federal income tax return NEXT YEAR: ☐YES ☐NO
(You can still apply for health insurance even if you do not file a federal income tax return)

If YES, please fill out the information below:

Name	Sex	Date of Birth	Social Security Number (if applying)	Are they the primary tax filer? y/n	Are they a tax dependent? y/n	If yes, name of tax filer

Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

1. Is everyone in your household a U.S. Citizen or U.S. National? ☐ Yes ☐ No.
2. **If someone is not a U.S. Citizen or U.S. National,** does he/she have eligible immigration status? **If yes, who?** _____
   Date of entry: _____ Fill in the document type and ID Number below.
   a. Immigration document type _____ Document ID number _____.
   b. Has he/she lived in the U.S, since 1996? ☐ Yes ☐ No
   c. If he/she has been in the U.S. for less than 5 years please enter the immigrant status (refugee, asylee, etc) _____
   d. Are you or your spouse or parent a veteran or an active-duty member of the U.S. Military? ☐ Yes ☐ No
3. Is anyone in the household pregnant? ☐ Yes ☐ No **If yes, who?** _____
   If yes how many babies are expected during this pregnancy? _____ What is the expected due date?_____
4. Are there women in your household between the ages of 18 and 56 and in need of family planning services (birth control, STD screen, etc.)?
   ☐ Yes ☐ No **If yes, who?**
5. Is anyone in your household a full-time student? ☐ Yes ☐ No **If yes,** fill in the information below**:**

   Name: _____ type of school (high school, college, etc.) _____ Expected graduation date? _____
   Name: _____ type of school (high school, college, etc.) _____ Expected graduation date? _____
   Name: _____ type of school (high school, college, etc.) _____ Expected graduation date? _____
   Name: _____ type of school (high school, college, etc.) _____ Expected graduation date? _____

6. Was anyone in your household in foster care at age 18 or older? ☐ Yes ☐ No **If yes, who?** _____
7. Is anyone in the household an employee **for** the State of Missouri? ☐ Yes ☐ No **If yes, who?** _____
8. Is anyone in your household temporarily away from home? ☐ Yes ☐ No If Yes, Who? _____
   If Yes, answer the following: Why is this person away? _____
   Date this person left the home: _____ Date this person is expected to return home: _____
   Current address where this person resides: _____

NEED HELP WITH YOUR APPLICATION? Visit **mydss.mo.gov** or call us at **1-855-373-9994**. Para obtener una copia de este formulario en Español, llame **1-855-373-9994**. TTY users call 1-800-735-2966

STEP 2: Income Information

Name of household member with earned income:

1. Employer name and address

2. Employer phone number ( ) –

3. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

4. Average hours worked each WEEK _____

5. Job start date: _____

Name of household member with earned income:

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$ _____

9. Average hours worked each WEEK _____

10. Job start date: _____

11. **In the past year**, did this person: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

12. **If anyone in the household self-employed**, answer the following questions: a. Name: _____
b. Type of work _____
c. How much net income (profits once business expense are paid) will this person get from self-employment this month?
$ _____

13. **OTHER INCOME THIS MONTH**: Check all that apply, and give the amount and how often this person gets the income.
NOTE: Income types including child support, veteran's benefits, gifts Supplemental Security Income (SSI), American Indian/Alaskan Payments, and educational assistance do not count for certain types of MO HealthNet Assistance. Only tell us about these types of income if you are applying for someone who is age 65 or older, or who has a disability. Name: _____

☐ None
☐ Unemployment **$** _____ How often? ____
☐ Pensions **$** _____ How often? ____
☐ Social Security **$** _____ How often? ____
☐ Retirement accounts **$** _____ How often? ____
☐ Alimony received **$** _____ How often? ____
☐ Net Farming/fishing **$** _____ How often? ____
☐ Net rental/royalty **$** _____ How often? ____
☐ Other income **$** _____ How often? ____
☐ Type _____

14. **DEDUCTIONS:** Check all that apply, and give the amount and how often this person pays the deduction.
Name: _____

If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: do not include a cost that is already considered in this person's answer to net self-employment.

☐ Alimony Paid **$** _____ How often? ____
☐ Student loan interest **$** _____ How often? ____
Other deductions **$** _____ How often? ____
☐ Type _____

15. YEARLY INCOME: Complete only if income changes from month to month.
If this person does not expect changes to monthly income, skip to the next person.

This person's total income **this year**	This person's total income **next year** (if he/she think it will be different)
$	$

Thanks! This is all we need to know about your household

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STEP 3: Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health care coverage now from the following?

☐ No. If no, continue to step 4.

☐ **Yes. If yes**, check the type of coverage and complete chart below:

☐ MO HealthNet ☐ Peace Corps ☐ Medicare ☐ VA Health care programs ☐ Employer sponsored insurance

☐ TRICARE/CHAMPUS (do not check if you have direct care for Line of Duty) ☐ Other health insurance

Please complete the following information:	Plan 1:	Plan 2:
	Applicant(s):	Applicant(s):
Policy Number / Medicare Claim Number:		
Group Name:		
Group Number:		
Insurance Company Name::		
Policy Holder Name:		
Policy Holder SSN:		
Policy Holder Date of Birth:		

2. Does this health insurance cover full maternity benefits, including prenatal care, labor, and delivery? ☐ Yes ☐ No
3. Does this insurance cover family planning services? ☐ Yes ☐ No
4. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

   ☐ Yes. If yes, you will need to complete and include Appendix A. Is this a state employee benefits plan? ☐ Yes ☐ No

   ☐ No. If no, continue to Step 4.

5. An individual **cannot** have more than one type of MO HealthNet coverage at a time. If you or someone in your household already has MO HealthNet coverage and you are requesting a **change in coverage** for that person, please answer the following:
6. Name: _____ Current coverage type: _____

   Seeking coverage type: _____

   ☐I understand that I am seeking a **change in coverage** for the person listed above. If found eligible for the coverage being sought, current coverage for this person will **close**. If found ineligible, then current coverage will remain active.

   EXAMPLE: Name: Jane Smith Current coverage type: MO HealthNet for the Aged, Blind or Disabled
   Seeking coverage type: MO HealthNet for Pregnant Women.

   For questions regarding coverage types and services, you may contact the Participant Services Unit (PSU) at 1-800-392-2161.

STEP 4:

1. Has anyone on the application received medical services in the last 3 months? ☐ No ☐ Yes, if so who?_____

   Please enter household income from 3 months ago: _____ 2 months ago: _____ 1 month ago:_____

2. Does anyone on the application use tobacco? ☐ No ☐ Yes, if so who?_____
3. Is anyone on the application in jail or prison? ☐ No ☐ Yes, if so who?_____
4. Has the individual been arrested but not convicted? ☐ Yes ☐ No What is the expected release date for this individual?_____

STEP 5: Read & sign this application.

MO HealthNet Rights and Responsibilities

PLEASE READ CAREFULLY AND SIGN BELOW

• I/we agree to provide Social Security Numbers of all persons applying for MO HealthNet as required by law. The Social Security Number is used to determine eligibility and verify information.

• I/we agree to be evaluated for the Health Insurance Premium Payment Program (HIPP) if I or members of the household are employed or lost employment in the last 30 days and the employer or former employer offers group health insurance.

• I/we agree that statements and information provided may be verified.

• I/we will report any changes in circumstances within TEN DAYS of when they happen.

• I/we know it is against the law to obtain or attempt to obtain benefits to which I am/we are not entitled. Any false claim, statement, or concealment of any material fact whatever, in whole or in part, may subject me/us to criminal and/or civil prosecution.

• I/we agree that by being determined eligible for MO HealthNet for a child who is deprived of parental support, I/we have assigned all rights to medical support to the State of Missouri, and that I/we must cooperate in establishing paternity and obtaining medical support, unless I/we have good cause. Failure to cooperate does not affect a child's eligibility.

• I/we understand healthcare benefits based on a person being age 65 and over, blind or disabled is not determined by completing this application. For healthcare benefits explored on the basis of being age 65 or over, blind or disabled, I/we must complete a different application for these benefits.

• I/we understand acceptance of MO HealthNet constitutes an assignment of rights to the Department of Social Services, MO HealthNet Division for payment for medical care from a third party.

• I/we agree that medical information about me and/or my family can be released if needed for treatment, payment of medical expenses, health care operations, and/or to administer this program.

• If I am/we are found to be eligible for MO HealthNet I/we know the state of Missouri will pay for covered services on my/our behalf and agree the state may file a claim against my/our estate to recover any assistance received.

• By signing this application on paper or electronically, you are giving us permission to deliver, or cause to be delivered, phone calls to you regarding your case from an automated dialing system at the primary phone number you provided on page 2. You do not have to consent to this as a part of your application. If you want to opt out of getting these calls, check here: ☐

If anyone on this application is eligible for MO HealthNet

• I am giving to the Family Support Division our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Family Support Division rights to pursue and get medical support from a spouse or parent.

• Does any child on this application have a parent living out of the home? ☐ Yes ☐ No

• If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Family Support Division and I may not have to cooperate.

Continue on next page

STEP 5: Read & sign this application continued

I am signing this application under penalty of perjury which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.

- I know that I must tell the Family Support Division if anything changes (is different than what I wrote on this application). I can visit **mydss.mo.gov** or call **1-855-373-9994** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting **http://dss.mo.gov/files/missouri-nondiscrimination-policy-statement.htm.**
- Is anyone applying for health insurance on this application is incarcerated (detained or jailed). ☐ Yes ☐ No
  If yes, write the name of the person here:_____.
  ☐ Check here if this person is pending disposition of charges.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We will check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

My right to appeal

If I think the Family Support Division has made a mistake, I can appeal its decision. To appeal means to tell someone at the Family Support Division that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by calling the Contact Center at **1-855-373-9994**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out step 1 should sign this application. If you are an authorized representative, you may sign here, as long as you have provided the information required in Appendix C.

SIGN HERE

Signature of Applicant	Date (mm/dd/yyyy)

STEP 6: Mail completed application.

Mail your signed application supplement (include all pages) to:

FSD Application Processing Center
PO Box 1353
Joplin, MO 64802-1353

If you want to register to vote, you can complete a voter registration form at:
http://sos.mo.gov/elections/goVoteMissouri/register.aspx