|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | MISSOURI DEPARTMENT OF SOCIAL SERVICES  FAMILY SUPPORT DIVISION  **REQUEST FOR INFORMATION** | | | | | |
| FROM | | COUNTY OFFICE | | | TELEPHONE NUMBER    -   - | | | DATE 08/10/2017 |
|  | | COUNTY OFFICE ADDRESS (STREET, CITY, STATE, ZIP CODE) | | | | | | |
| TO | | NAME | | | Head of Eligibility Unit | | | |
|  | | ADDRESS (STREET) | | | DCN | | | |
|  | |  | | | Head of Eligibility Unit DCN | | | |
|  | | CITY STATE ZIP CODE | | |  | | | |
| PROGRAM  Show-Me Babies | | | | | | | | |
| The items and/or tasks listed below must be returned to this office and/or completed to determine your eligibility for assistance. All items pertain to you and/or all members included in your eligibility unit. **Failure to provide the requested information may affect the decision made on your case.** | | | | | | | | |
| **To avoid any delays in the processing of your case, return the items and/or complete the tasks listed below no later than      .** | | | | | | | | |
| **PROOF OF:** | | | | | | | | |
|  | **Insurance information is needed to determine your potential eligibility under Show-Me Healthy Babies if you are denied MO HealthNet for Pregnant Women (MPW).** | | | | | | | |
|  | **See Other below for further details.** | | | | | | | |
|  | **Do you have employer sponsored insurance Y or N\_\_\_ (enter Y or N)? If not is this available to you Y or N\_\_\_ (enter Y or N), and if yes how much does it cost per month? $\_\_\_\_\_\_\_\_\_ (enter cost per month).** | | | | | | | |
|  | **Does this include maternity (prenatal, labor and delivery, and postpartum) coverage? Y or N \_\_\_ (enter Y or N).** | | | | | | | |
|  | **Do you have any other insurance such as private insurance, or insurance through a university as a full time student, Y or N\_\_\_ (enter Y or N). If the answer is yes what is the monthly cost? $\_\_\_\_\_\_.** | | | | | | | |
|  | **If you are insured through a private or university plan does this cover maternity as defined above? Y or N \_\_\_ (enter Y or N).** | | | | | | | |
|  |  | | | | | | | |
|  |  | | | | | | | |
|  |  | | | | | | | |
| **\*Your MPW application must be denied for specific reasons to have eligibility under Show-Me Healthy Babies evaluated.**  **We must evaluate your availability of insurance for the Show-Me Healthy Babies program. You may supply answers to the above questions verbally or in writing to the phone number or fax number shown below. If the above questions are not answered your Show-Me Healthy Babies application will be denied for failure to cooperate once the date above has expired. This form serves as the request for this necessary information as well as a format for you to answer the necessary questions.**  **If you are approved for MPW this request may be ignored.**  **Insurance affordability will be determined per CHIP policy.** | | | | | | | | |
| **IMPORTANT IMPORTANT IMPORTANT IMPORTANT IMPORTANT IMPORTANT** | | | | | | | | |
| **IF YOU HAVE ANY QUESTIONS OR EXPERIENCE A DELAY IN SECURING ANY OF THE ABOVE ITEMS, CONTACT YOUR WORKER IMMEDIATELY:** | | | | | | | | |
| Eligibility Specialist | | | | Load | | Phone       -     - | Fax       -     - | |

IM-31A SMHB ELECTRONIC (01/2016)