Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

Application for Health Coverage & Help Paying Costs

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost insurance from MO HealthNet.

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you are not eligible for coverage. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

- Apply faster online at **mydss.mo.gov**.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance).
- Employer and income information for everyone your family (for example, from paystubs, W-2 forms, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your family.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law.**

What happens next?

Send your complete, signed application to the address on page 8. **If you do not have all the information we ask for, sign and submit your application anyway.** We will follow-up with you. You will get instructions on the next steps to complete your health coverage application. If you do not hear from us, call **1-855-373-9994**. Filling out this application does not mean you have to buy health coverage.

Get help with this application

- Online: **mydss.mo.gov**.
- Phone: call our Contact Center 1-855-373-9994.
- In Person: at any local Family Support Division office or there may be counselors in your area who can help. Visit HealthCare.gov or call 1-800-318-2596 for more information.
- En Español: Llame a nuestro centro de ayuda gratis al 1-855-373-9994.
- TTY users call 1-800-735-2966.

STEP 1 Tell us about the adult who will be our main contact for this application

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

Did you obtain this application from a:
☐ Missouri Public School ☐ Licensed Child Care Provider ☐ Other

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:

19. What is your preferred spoken or written language (if not English)

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 applicant and family

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 each person in your family. Start with <u>yourself</u>! Then add other adults and children.

- **If you have more than 2 people in your family**, you will need to make additional copies of pages 4 - 5 for each additional person and attach them.
- 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.

NEED HELP WITH YOUR APPLICATION? Visit **<u>mydss.mo.gov</u>** 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: PERSON 1 (Start with yourself/applicant)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

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

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex: ☐ Male ☐ Female

5. U.S. Veteran: ☐ Yes ☐ No ☐ Unknown

6. Social Security Number (SSN) _____.

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you do not want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

7. ☐ Check here if you are a member of an American Indian or Alaska Native federally recognized tribe, and fill out Appendix B.

8. Do you need health coverage? (Even if you have insurance, there may a program with better coverage or lower costs.)
☐ **YES**. **If yes**, answer all the questions below. ☐ **NO**. **If no**, SKIP to the income questions on page 3. Leave the rest of this page blank.

9. **If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

10. **Race (OPTIONAL – check all that apply.)**

☐ White	☐ American Indian or Alaskan Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

11. Are you a U.S. Citizen or U.S. National? ☐ Yes ☐ No.

12. **If you are not a U.S. Citizen or U.S. National,** do you have eligible immigration status?

☐ Yes. Date of entry: _____ Fill in your document type an ID Number below.

a. Immigration document type _____ Document ID number _____.

b. Have you lived in the U.S, since 1996? ☐ Yes ☐ No

c. Are you or your spouse or parent a veteran or an active-duty member of the U.S. Military? ☐ Yes ☐ No

d. If you have been in the U.S. for less than 5 years please enter your immigrant status (refugee, asylee, etc) _____

13. Are you pregnant? ☐ Yes ☐ No
If yes how many babies are expected during this pregnancy? _____ What is your expected due date?_____

14. Are you a woman between the ages of 18 and 56 and in need of family planning services (birth control, STD screen, etc.)? ☐ Yes ☐ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

16. Are you a full-time student? ☐ Yes ☐ No

If yes, type of school (high school, college, etc.) _____ What is the expected graduation date? _____

17. Were you in foster care at age 18 or older? ☐ Yes ☐ No

18. If you are under age 18, is one of your parents an employee for the state of Missouri? ☐ Yes ☐ No

19. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you do not file a federal income tax return.)

☐ **Yes**. **If yes**, please answer questions a-c. ☐ **No**. If no, skip to question c.

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

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, name(s) of dependents: _____.

c. Will you be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____.

How are you related to the tax filer? : _____.

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: PERSON 1 (Continue with yourself)

Current Job & Income information

☐ Employed
If you are currently employed, tell us about your income. Start with Question 20.

☐ Not Employed
Skip to question 29.

☐ Self-employed
Skip to question 28.

Current Job 1:

20. Employer name and address

21. Employer phone number

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

$ _____

23. Average hours worked each WEEK

24. Job start date:

Current Job 2:

24. Employer name and address

25. Employer phone number

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

$ _____

25. Average hours worked each WEEK

26. Job start date:

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

28. **If self-employed, answer the following questions:**
a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from self-employment this month?

$ _____

29. **OTHER INCOME THIS MONTH**: Check all that apply, and give the amount and how often you get it.
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.

☐ 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 _____

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If you pay 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: you should not include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony Paid **$** _____ How often? ____

☐ Student loan interest **$** _____ How often? ____

☐ Other deductions **$** _____ How often? ____

Type _____

31. YEARLY INCOME: Complete only if your income changes from month to month.
If you do not expect changes to your monthly income, skip to the next person.

Your total income **this year**
$

Your total income **next year** (if you think it will be different)
$

Thanks! This is all we need to know about you.

Please complete pages 4 and 5 for additional household members, make copies if necessary.

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: PERSON # ☐ (Please list additional individual as person 2, 3, 4 and so on)

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

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

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex: ☐ Male ☐ Female

5. U.S. Veteran: ☐ Yes ☐ No ☐ Unknown

6. Does this person live at the same address as you? ☐ Yes ☐ No **If no**, list address

7. Social Security Number (SSN) _____. **We need this for any individual who wants health coverage and has an SSN**.
If he/she doesn't have a number have you applied for one? ☐ Yes ☐ No. **If no**, reason: _____

8. ☐ Check here if you are a member of an American Indian or Alaska Native federally recognized tribe, and fill out Appendix B.

9. **If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

10. **Race (OPTIONAL – check all that apply.)**

☐ White	☐ American Indian or Alaskan Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

11. Does this person need health coverage? (Even if he/she has insurance, there may a program with better coverage or lower costs.)
☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no**, SKIP to the income questions on page 5. Leave the rest of this page blank.

12. Is this person a U.S. Citizen or U.S. National? ☐ Yes ☐ No. If U.S. National verification document: ☐ Cert. of Naturalization or Citizenship ☐ Passport ☐ I-551 (Permanent Resident Card)

13. If this person is not a U.S. Citizen or U.S. National, does he/she have eligible immigration status?
☐ Yes. Date of entry: _____ Fill in the document type an ID Number below.
   a. Immigration document type _____. Document ID number _____.
   b. Has he/she lived in the U.S, since 1996? ☐ Yes ☐ No
   c. Is he/she or his/she spouse or parent a veteran or an active-duty member of the U.S. Military? ☐ Yes ☐ No
   d. If he/she is in the U.S. for less than 5 years please enter immigrant status (refugee, asylee, etc) _____

14. Is this person pregnant? ☐ Yes ☐ No
If yes how many babies are expected during this pregnancy? _____ What is the expected due date?_____

15. Has this person recently lost health insurance coverage? ☐ Yes ☐ No If yes, date of loss:_____ Reason:_____

16. If this person is under age 18, is a parent an employee for the state of Missouri? ☐ Yes ☐ No

17. Is this person a woman between the ages of 18 and 56 and in need of family planning services (birth control, STD screen, etc.)? ☐ Yes ☐ No

18. Does he/she live with at least one child under the age of 19, and is he/she the main person taking care of this child? ☐ Yes ☐ NO

19. Did the person have insurance through a job and lose it within the past 3 months?
☐ Yes ☐ No **If yes**, end date: _____ b. Reason the insurance end:_____

20. Is this person a full-time student? ☐ Yes ☐ No
If yes, type of school (high school, college, etc.) _____ What is the expected graduation date? _____

21. Was this person in foster care at age 18 or older? ☐ Yes ☐ No

22. **Does this person plan to file a federal income tax return NEXT YEAR?**
(This person can still apply for health insurance even if he/she do no file a federal income tax return.)
☐ **Yes. If yes**, please answer questions a-c. ☐ **No. If no**, skip to question c.
   a. Will this person file jointly with a spouse? ☐ Yes ☐ No
   If yes, name of spouse: _____
   b. Will this person claim any dependents on your tax return? ☐ Yes ☐ No
   If yes, name(s) of dependents: _____
   c. Will this person be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
   If yes, name(s) of tax filer: _____

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: PERSON # ☐ (Please list additional individual as person 2, 3, 4 and so on)

Current Job & Income information

☐ Employed If this person is currently employed, tell us about his/her income. Start with Question 22.	☐ Not Employed Skip to question 34.	☐ Self-employed Skip to question 33.

Current Job 1:

23. Employer name and address	24. Employer phone number

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

26. Average hours worked each WEEK	27. Job start date:

Current Job 2:

28. Employer name and address	29. Employer phone number

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

31. Average hours worked each WEEK	32. Job start date:

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

34. **If self-employed**, answer the following questions:
Type of work _____

b. How much net income (profits once business expense are paid) will this person get from self-employment this month?
$ _____

35. **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.

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

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

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 (question 26b).

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

37. 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 this person.

If you have more than two people to include, make a copy of pages 4 and 5 to complete for each additional individual.

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 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. 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.

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?_____

5. Is anyone applying for benefits in the household blind? ☐ No ☐ Yes, if so who?_____

6. Is anyone applying for benefits in the household disabled? ☐ No ☐ Yes, if so who?_____

7. Does anyone in the household applying for benefits have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ No ☐ Yes, if so who? _____

8. Does anyone in the household applying for benefits live in a medical facility or nursing home? ☐ No ☐ Yes, if so who? _____

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 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

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 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 (include all pages) to:

FSD Application Processing Center
PO BOX 1353
Joplin, MO 64802

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

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

APPENDIX A

Health Coverage from Jobs

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee legal name	2. Employee Social Security Number

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN)	
5. Employer Address	6. Employer Phone Number	
7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (If different from above)	12. Email address

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you are in a waiting or probationary period, when can you enroll in coverage? _____

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premium for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer will not offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? ? **$**_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of Change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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.**

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you are eligible for (even if it is from another person's job, like a spouse). The information in the numbered boxes below match the boxes on Appendix A. For Example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information (The **employee** needs to fill out this section.)

1. Employee legal name (First, Middle, Last)	2. Employee Social Security Number

EMPLOYER Information (Ask the **employer** for this information.)

3. Employer name	4. Employer Identification Number (EIN) _____-_____	
5. Employer Address (the Family Support Division will send notices to this address)	6. Employer Phone Number	
7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (If different from above)	12. Email address

13. **Is the employee currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)

☐ **No** (Stop here and return this form to the employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?
☐ Yes Which people? ☐ Spouse ☐ Dependent(s)

☐ No (Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

a. How much would the employee have to pay in premium for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premium for this plan? **$** _____

How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you do not know, Stop and return form to employee.

16. What change will the employer make for the new plan year (if known)?

☐ Employer will not offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

How much will the employee have to pay in premiums for that plan? **$**_____How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly Date of Change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following question to make sure your family gets the most help possible

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	**AI/AN PERSON 2**
1. Enter name(s) in next column(s)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐Yes ☐No **If yes**, tribe name:_____ **State** where seat of Tribal Government is located:_____	☐Yes ☐No **If yes**, tribe name:_____ **State** where seat of Tribal Government is located:_____
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐Yes ☐No **If no**, is this person eligible to get services from Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐Yes ☐No	☐Yes ☐No **If no**, is this person eligible to get services from Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐Yes ☐No
4. Certain money received may not be counted for MO HealthNet. List any income (type, amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	Type _____ $ _____How often?_____ Type_____ $ _____How often?_____ Type_____ $ _____How often?_____	Type_____ $ _____How often?_____ Type_____ $ _____How often?_____ Type_____ $ _____How often?_____

APPENDIX C

Assistance with Completing this Application

You do not need to sign appendix C to apply for or receive MO HealthNet benefits. You may contact the Family Support Division to apply for benefits, complete your annual review, or conduct other business on your own; or you may appoint an authorized representative to represent you, as provided by 42 CFR 435.908. To appoint an authorized representative, you must complete this form and the person you appoint to be your authorized representative must acknowledge and accept the appointment. **Notwithstanding the availability of the authorized representative, the Family Support Division may communicate directly with you as the division may determine appropriate.**

I, _____ TELEPHONE NUMBER: _____

ADDRESS _____ DCN or SSN: _____

HEREBY APPOINT

NAME: _____ TELEPHONE NUMBER: _____

ADDRESS: _____ EMAIL ADDRESS: _____

TO ACT AS MY AUTHORIZED REPRESENTATIVE.

This individual/organization is designated as my authorized representative to receive correspondence from the Family Support Division. ☐ YES ☐ NO

The appointed individual/organization will act with a responsibility and obligation to me for the following purpose:

☐ APPLICATION ☐ ONGOING AGENCY ACTIONS ☐ BOTH

The person/organization I have appointed has knowledge of my circumstances necessary to complete an application, annual review or act on my behalf and shall not willfully make a false statement, misrepresentation, conceal information, or fail to report any fact or event required to be reported by any law, regulation or rule of this State or the United States.
I understand that I am responsible for the information provided by my authorized representative, including any information that may be incorrect.

APPLICANT/PARTICIPANT SIGNATURE	DATE

Request and Authorization to disclose Protected Health and Other Information:

I ,_____,**HEREBY** request and authorized Family Support Division to disclosed information to _____ to include requests for information necessary to determine eligibility, eligibility notices, and access to medical information pertaining to this application, annual review or agency action to the individual authorized above to receive the information. (Note: requests for information, eligibility notices and protected health information must be sent to the attention of the individual named above, not the entity they represent.

This request for disclosure and authorization to release shall continue until final disposition of the application, annual review or agency action for which this request and authorization to disclose was submitted unless revoked by me in writing prior to final application, annual review or agency action disposition.

By requesting and authorizing disclosure of Protected Health Information (PHI), I understand that the Family Support Division is not responsible for what happens to the information disclosed. I understand and acknowledge I have been provided a copy of this form.

Continue on next page

Appendix C continued:

Acknowledgement and Acceptance of Appointment of Authorized Representative:	
I, (PRINT NAME)	TELEPHONE NUMBER
ADDRESS	
am age 18 or older (not applicable to organization) and have knowledge of the applicant/participant's circumstances necessary to complete an application, annual review or agency action on their behalf. I (or this organization) shall not willfully make a false statement, misrepresentation, conceal information, or fail to report any fact or event required to be reported by any law, regulation or rule of this State or the United States. I (or this organization) hereby accept this appointment of authorized representative for the duration and purpose stated above. I will protect the confidentiality of all information that I may receive while acting the authorized representative in accordance with applicable Federal, State and local laws, regulations, ordinances, and directives relating to confidentiality.	
AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

Print Reset