MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

REQUESTING INPATIENT COVERAGE FOR SUSPENDED PARTICIPANTS

SAVE PRINT RESET

Date: _____

Participant's Name: _____

Date of Birth: _____

Social Security Number or DCN: _____

MO HealthNet is currently suspended: ☐ YES ☐ NO

If MO HealthNet is NOT suspended DO NOT USE THIS FORM. An application for eligibility is REQUIRED.

Medical facility where admitted (name and address):

Date admitted to medical facility:

Date released from medical facility (returned back to jail or prison):

Other information (DO NOT INCLUDE SPECIFIC MEDICAL INFORMATION):
Example: Newborn name, DOB, address/placement. Participant died. Participant was released and did not return to jail/correction facility, address where released.

Reporter's Name and Contact Information:

Send by email: MHNJailsandDOCReport@ip.sp.mo.gov; or fax: (573) 751-0050
Family Support Division may use this form to request additional information as needed.