MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
REPORTING RELEASE OF MO HEALTHNET PARTICIPANT

SAVE PRINT RESET

Date of Release
(or Expected Date): _____

Client's Name: _____

DCN:	Social Security Number:
DOB:	Phone Number at release (if known):

Household information:

Are you returning to the same household as prior to custody? ☐ YES ☐ NO

If no, please provide all household members and relationship to self [ex: Full Name (relationship): Jane Doe (unrelated)]:

Physical address upon release:

Mailing address upon release (if different from physical address):

Expected income source/amount/hour per pay period/frequency:

Are you:
Disabled? YES ☐ NO ☐ Blind/Visually Impaired? YES ☐ NO ☐
Pregnant? YES ☐ NO ☐ Former Foster Child? YES ☐ NO ☐

****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.