Missouri Family Support Division
PO Box 2700
Jefferson City, MO 65102

Missouri Department of SOCIAL SERVICES

Date notice generated

<First name><Last name>
<123 Smith Street>
<Jefferson City, MO 65101>

DCN: <#12345678>

MO HealthNet Review Form

Date:

IMPORTANT! Return this form by *DATE_DUE* to the address listed below. FSD will review it and call or send you a letter if more information is needed. If you do not return this form your MO HealthNet coverage will end.

Jefferson City Processing Center
PO Box 2700
Jefferson City, MO, 65102

Family Support Division must review information for everyone who has MO HealthNet, at least once a year. We need to complete the review to determine if you or your family members remain eligible for MO HealthNet. When answering the questions, please answer for every member of your household. Listed below are the type(s) of benefits you currently receive and a list of sections you should complete. If your name appears next to a program below, you need to complete the sections listed in the right hand column. If you don't have enough room to answer all of the questions, complete section E or attach pages.

If you have questions or need help with this form please call the Family Support Division Contact Center at 855-373-9994.

The Social Security Number is needed only for those who have MO HealthNet or are applying for MO HealthNet. Race and ethnicity information is used in our reports. You do not have to give us that information.

We have prepopulated this form with the information that we currently have on your MO HealthNet case. Please review and make any changes necessary to reflect your current circumstances. **Cross-out any information that is no longer correct and add any new information.**

After you fill out the form, please sign on the last page where it says "Signature/Affidavit/Mark".

If additional information is needed we will send a letter telling you what information is needed and the letter will have a date that you must return the information to avoid changes in your medical coverage.

Do you want to register to vote? If, so just fill out the voter registration form included with the review form and return it to the local Family Support office. If you don't fill out the form, MO HealthNet coverage will not be affected.

Current Benefits Received For Members Of Your Household		DCN : (HOH DCN)
Household Members	**MO HealthNet Program**	**You must complete sections:**
(Insert Name)	(LOC)	(Section to be Filled)
(Insert Name)	(LOC)	(Section to be Filled)

MO HEALTHNET ELIGIBILITY REVIEW FORM

Complete and return by: (HOH DCN)

SECTION A: Complete For All MO HealthNet Programs

Head of Eligibility Unit		DCN		
Street Address		City	State	Zip
Current Phone	Work Phone	Cell/Message Phone		

BELOW ARE ALL MEMBERS OF THE HOUSEHOLD

Name (First, Middle, Last) (Maiden)	Hispanic Yes or No	Race*/ Sex	Relationship to Primary Applicant
(Insert Name)			
(Insert Name)			

ADD MEMBERS OF YOUR HOUSEHOLD NOT LISTED ABOVE. ATTACH ADDITIONAL PAGES IF NEEDED.

Name (First, Middle, Last) (Maiden)	Hispanic Yes or No	Race*/ Sex	Relationship To Parent/Guardian	Birth Date	Social Security Number

*1 White
2 Black/African American
3 American Indian/Alaska Native
4 Asian
5. Native Hawaiian/Pacific Islander
6. Chinese
7.Filipino
8.Japanese
9. Korean
10. Vietnamese
11. Other Asian
12. Guamanian or Chamorro
13. Samoan
14.Other
15.I prefer not to answer at this time

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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 home? _____ Date this person is expected to return home? _____
Current address where this person resides? _____

Do you wish to start coverage for any of the above persons who are not currently covered by MO HealthNet?
☐ Yes ☐ No If Yes, who? _____

Is anyone in the household pregnant? ☐ Yes ☐ No
If Yes, who? _____ Expected due date? _____

Is anyone in the household blind or disabled? ☐ Yes ☐ No

Do you have a guardian, family member, representative or someone who handles your money? ☐ Yes ☐ No
If yes, who? _____
Address and Telephone Number?
_____

Has there been any change in citizenship or immigration status for individuals currently receiving MO HealthNet?
☐ Yes ☐ No

If Yes, list the individual whose status has changed with the current information in the blanks.

Name	Immigration Status	Registration Number	Date of Entry

INCOME AND EXPENSES: (Please include proof of all household income and expenses. This includes but is not limited to paycheck stubs for the last 30 days; letter from employer(s); copy of latest tax return or business records if self-employed; award letter for Social Security or pensions; and health insurance.)

Is anyone in your household employed? ☐ Yes ☐ No If Yes, complete the following and attach proof:

NAME	EMPLOYER NAME	EMPLOYER PHONE	PAY RATE	PER*	NET PAY (IF SELF EMPLOYED)	START DATE	MONTHLY GROSS INCOME	TIPS, ETC

ADD MEMBERS OF YOUR HOUSEHOLD NOT LISTED ABOVE. ATTACH ADDITIONAL PAGES IF NEEDED.

NAME	EMPLOYER NAME	EMPLOYER PHONE	PAY RATE	PER*	NET PAY (IF SELF EMPLOYED)	START DATE	MONTHLY GROSS INCOME	TIPS, ETC

*Hour Day Week Every two weeks Twice monthly Month Year

Client Name
Client DCN

SECTION A (continued): Complete For All MO HealthNet Programs	DCN : (HOH DCN)

Do you plan to file a federal income tax return Next Year?

☐ Yes. If yes, please answer 1-3 ☐ No. If no, skip to question 3.

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

If yes, name of spouse:

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

If yes, list dependents:

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

If yes, please list tax filer: How are you related to the tax filer?

Does anyone in your household operate a business or are self-employed? ☐ Yes ☐ No
If Yes, who? _____. If Yes, complete below and attach proof of income.

Describe the type of self-employment (babysitting, farm income, other) _____.
Enter amount earned _____ Per ☐ Hour ☐ Day ☐ Week ☐ Every two weeks ☐ Twice monthly ☐ Month

Do you expect any changes in your income or employment? (hours worked, employer or unearned income) ☐ Yes ☐ No If Yes explain:
_____

Is there anyone who plans to go to work? ☐ Yes ☐ No If Yes, who? _____
Where? _____ When? _____

Other Income Sources :

- <Person Name> has an income from <income source> in the amount of $<amount>.

Do you or any other household member receive money from any of the following sources? Attach additional pages if needed.

	Yes/ Amount	Name		Yes/ Amount	Name
Social Security			Union Funds or Pension Benefits		
Supplemental Security Income (SSI)			Insurance Settlements		
Alimony			Rent received from Land/Buildings		
Money from others (friends, relatives, etc.)			Room and/or Board Received		
Veteran's Benefits			Armed Forces Allotment		
Worker's Compensation			Money from Sale of Property		
Unemployment Compensation			Interest from Savings/Checking		
Disability or Sick Benefits			Income received from Trusts		
Income from Training Program			Income received from Annuities		
Any other income Explain:			VA Aid and Attendance		

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Has anyone recently applied for any of the above benefits? ☐ Yes ☐ No
If Yes, explain: _____

Do you or any other household member expect to pay for certain things that can be deducted on your next federal tax return? ☐ Yes ☐ No

If Yes, complete the following and attach verification:

Amount	Per*	Type (Alimony, student loan, other deductions)

* Week Every two weeks Twice monthly Month Year

SECTION B: Complete for MO HealthNet for Families and Kids | **DCN : (HOH DCN)**

HEALTH INSURANCE (other than MO HealthNet):

I/We have medical insurance. ☐ Yes ☐ No If Yes, complete the following:

NAME OF INSURED	NAME OF COMPANY	POLICY NUMBER	POLICY HOLDER	COVERAGE TYPE (DOCTOR OR HOSPITAL) IF LIMITED, EXPLAIN

ADD MEMBERS OF YOUR HOUSEHOLD NOT LISTED ABOVE. ATTACH ADDITIONAL PAGES IF NEEDED.

NAME OF INSURED	NAME OF COMPANY	POLICY NUMBER	POLICY HOLDER	COVERAGE TYPE (DOCTOR OR HOSPITAL) IF LIMITED, EXPLAIN

Does this insurance cover family planning services? ☐ Yes ☐ No

Has anyone in your home lost or dropped health insurance since approval or last review? ☐ Yes ☐ No
If Yes, provide name(s), date and reason coverage ended.
_____

Is health insurance available for any member of your family through an employer or other group membership?
☐ Yes ☐ No If Yes, enter name of employer or group_____

Is the insurance available for: ☐ Self ☐ Spouse ☐ Children
How much is the premium for the children? $ _____ per month _____

Are both parents of all the children in the home? ☐ Yes ☐ No If No, list child (ren) and name of absent parent(s).

Child: _____Absent Parent:_____
Child: _____Absent Parent:_____

Do you practice joint custody with the other parent of any of the children listed above? ☐ Yes ☐ No
If Yes, complete the following:
Child: _____ Absent Parent (AP): _____AP SSN:_____
Child: _____ Absent Parent (AP): _____AP SSN:_____
Send proof of the joint custody parent's income for the past month.

Do you have any new information about an absent parent(s)? ☐ Yes ☐ No If Yes, please give details:
_____

SECTION C: Complete for Uninsured Women's Health Services

Is health insurance available for any female member of your family, ages 18 up to 55 years old, through an employer or other group membership? ☐ Yes ☐ No
If yes, who? _____ If yes, name of employer or group? _____

Is any female member of your family, ages 18 up to 55 years old, insured? ☐ Yes ☐ No
If yes, who? _____ If yes, name of insurance? _____

If yes, does the available health insurance cover family planning services? ☐ Yes ☐ No
Do you still need family planning services? ☐ Yes ☐ No _____

SECTION D: Complete for all MO HealthNet Programs

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.

PLEASE READ CAREFULLY AND SIGN BELOW: (Signature of spouse in the home or the absent parent, if practicing joint custody, is also required)

- I/we agree to provide Social Security Numbers of all person 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 agree that by I/we will report any changes in circumstances within TEN (10) 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 whatsoever, in whole or in part, may subject me/us to criminal and/or civil prosecution.

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- 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 my child's eligibility.
- 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.

ATTENTION: Federal regulations require that the Missouri Department of Social Services (DSS) maintain a publicly available "Notice of Privacy Practices" that describes our policy for handling protected health information. The department has implemented a privacy policy and prepared a Notice of Privacy Practices. You may obtain a copy of this notice on the DSS Web site at http://www.dss.mo.gov/hipaa/hprivacy.pdf or from any county DSS office

My signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete to the best of my knowledge.

Your Signature/Affidavit/Mark : **Date:**	**Spouse or Second Parent Signature/Affidavit/Mark:** **Date:**
Signature/Affidavit of Joint Custody Parent: **Date:**	

SECTION E: Optional

ADDITIONAL INFORMATION: (If additional room is needed for any question please enter information here or attach an additional page. **Attach proof of information as requested**)