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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | MISSOURI DEPARTMENT OF SOCIAL SERVICES  FAMILY SUPPORT DIVISION  **REQUEST FOR INFORMATION** | | | | | | |
| FROM | COUNTY OFFICE | | | | TELEPHONE NUMBER    -   - | | | DATE 12/17/2015 |
|  | 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 | | | | | | | | |
| 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 eligibility under Show-Me Healthy Babies as you were denied Medicaid for Pregnant Women.** | | | | | |
|  | | | **See Other below for futher details.** | | | | | |
|  | | | **Do you have employer sponsored insruance, or is this available to you, and if so how much does it cost?** | | | | | |
|  | | | **Enter cost here:** | | | | | |
|  | | | **Does this include maternity (prenatal, labor and delivery, and postpartum coverage?** | | | | | |
|  | | | **Enter the answer here:** | | | | | |
|  | | | **If you do not have access to employer sponsored insurance or other insurance you must explore private insurance by obtaining two quotes from different companies.** | | | | | |
|  | | | **Two forms are included to help you with obtaining these quotes. Please include if they cover maternity benefits (prenantal, labor and delivery, and postpartum)** | | | | | |
|  | | |  | | | | | |
| **We must evaluate your availability of insurance for the Show-Me Healthy Babies program. You may supply this information verbally through self attestation. 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 along as a format for you to answer the necessary questions.** | | | | | | | | |
| **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       -     - | |

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