INSTRUCTIONS

This document (Incarcerated Applicant HIGHLIGHTED Questions_IM-1SSL-Fillable Medicaid Application-9.2023.pdf) is a **TEMPLATE ONLY**. Please do not use this version to send in applications. It is for reference only.

Questions highlighted in **GREEN** can be filled out by the jail ahead of time.

Questions highlighted in **YELLOW** should be filled out with the incarcerated applicant.

Save Print Reset

Missouri Department of Social Services
Family Support Division
Application for Health Coverage & Help Paying Costs

Use this application for all MO HealthNet programs. You may also need to fill out the Aged, Blind, and Disabled Supplement (IM-1ABDS) if you are over 65, blind, disabled, or living in a nursing home or long-term care facility.

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from MO HealthNet.
- 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.

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child(ren) already have 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.
- If you are applying for your unmarried domestic partner, both of you will 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 in 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 you to fill out, 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 **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 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 800-318-2596 for more information.
- En Español: Llame a nuestro centro de ayuda gratis al 855-373-9994.
- TTY users call 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 (Write HOMELESS if you are currently without a home address) Apartment or suite number

City State ZIP code County

3. ☐ Check here if your mailing address is different than your home address. **If it is different**, provide your mailing address below:

4. ☐ Check here if the mailing address provided is a Safe at Home address. Safe at Home authorization code _____

5. Mailing Address 6. Apartment or suite number

7. City 8. State 9. ZIP Code 10. County of residence

11. Phone number
☐ Home ☐ Cell ☐ Work ☐ Message

12. Other phone number and type (message, work, cell)
☐ Home ☐ Cell ☐ Work ☐ Message

13. Email address:

14. What is your preferred method of contact? ☐USPS mail ☐ Email ☐ Phone ☐ Text

15. What is your preferred language (if not English)? :

16. How well do you speak English? ☐ Very Well ☐ Well ☐ Not Well ☐ No Spoken Proficiency ☐ Prefer not to answer

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, use my tax returns to renew my eligibility automatically for the next:
☐ 5 years (the maximum number of years allowed)
☐ 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

Complete Step 2 for each person in your family. Start with yourself! 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.

Tell us about all the family members who live with you. 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.

You don't need to file taxes to get health coverage.

For adults who need coverage:
Include these people even if they aren't applying for health coverage for themselves:
• Any spouse they live with
• Any child under age 21 they live with, including stepchildren
• Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return).

For children under age 21 who need coverage:
Include these people even if they aren't applying for health coverage themselves:
• Any parent (or stepparent) they live with
• Any sibling they live with
• Any child they live with, including stepchildren
• Any spouse they live with
• Any other person on the same federal income tax return.

Note: Anyone else who lives with you - for example, a boyfriend, girlfriend, or roommate – will need to file their own application if they want health insurance, unless you both fill out Appendix C.

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 mydss.mo.gov or call us at 855-373-9994. Para obtener una copia de este formulario en Español, llame 855-373-9994. TTY users call 800-735-2966

STEP 2: PERSON 1 (Start with yourself/applicant)

Complete Step 2 for yourself, your spouse 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. For an adult to qualify for Adult Expansion Group, children in their care living in the same home must qualify for MO HealthNet or receive other Minimum Essential Coverage. Provide information on Step 3 regarding medical coverage for children in this person's care.

1. Legal Name (First name, Middle name, Last name, & Suffix)	2. OPTIONAL- Are you: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Legally Separated ☐ Other	3. Relationship to you? **SELF**
abalasdf kalsdjf		
4. Date of birth (MM/DD/YYYY)	5. Sex: ☐ Male ☐ Female	6. OPTIONAL - Are you a US Veteran? ☐ Yes ☐ No ☐ Prefer not to answer

7. Social Security Number (SSN) _____. **We need this if you want health coverage and have a SSN**.
Providing your SSN can be helpful even if you do not want health coverage 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 800-772-1213 or visit socialsecurity.gov. TTY users should call 800-325-0778.

8. ☐ Check here if you are an American Indian or Alaska Native and fill out Appendix D.

9. ☐ Check here if you want help paying for medical bills for the 3 months prior to this application and fill out Appendix A.

10. **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**, 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
c. Will you be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
If yes, list the name of the tax filer _____ How are you related to the tax filer? _____

11. Are you requesting health coverage from this month forward? 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 question 24.

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

13. Race (OPTIONAL – check all that apply.)

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

14. Are you a US Citizen or US National? ☐ Yes ☐ No

15. Are you a naturalized or derived US Citizen? (This usually means you were born outside the US.) ☐ Yes ☐ No
Alien Number: _____ Certificate Number: _____

16. ☐ Check here if you are not a US Citizen or US National, but you have an eligible immigrant status. Provide the following information.
Immigration Status Start Date: _____ Fill in your document type and ID Number below.
a. Immigration document type _____ Document ID number _____.
b. Have you lived in the US, since 1996? ☐ Yes ☐ No
c. Are you or your spouse or parent a veteran or an active-duty member of the US Military? ☐ Yes ☐ No
d. If you have been in the US for less than 5 years please enter your immigrant status (refugee, asylee, etc.) _____

17. ☐ Check here if you are pregnant, or were recently pregnant. Provide the information below.
If yes, how many babies are expected during this pregnancy? _____ What is your expected due date? _____
If you were recently pregnant, what was the date the pregnancy ended? _____

18. ☐ Check here if you live with at least one child under the age of 19, and you are the main person taking care of this child.

19. ☐ Check here if you are a full-time student in high school, equivalent vocational training, or technical training.
Type of school (high school, college, etc.) _____

20. ☐ Check here if you were in foster care at age 18 or older. What state were you in care? _____

21. ☐ Check here if you are under age 19 and eligible to enroll in healthcare as part of a state employee benefit plan.

22. ☐ Check here if you receive or you are eligible to receive Medicare. When did you become eligible? _____

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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 23.
☐ Self-employed - Skip to question 33.
☐ Not employed - Skip to question 34.

Current Job 1: ☐ Check here if taxes are not withheld from this income before you receive it.

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: ☐ Check here if taxes are not withheld from this income before you receive it.

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. 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? $ _____

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

35. **Other income this month:** Check all that apply, and give the amount and how often this person gets the income.

☐ None
☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Alimony received $_____ How often? _____
Date of order or last modification:_____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ 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 34b).

☐ Alimony Paid $_____ How often? _____
Date of order or last modification:_____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type: _____

37. Yearly income: Complete only if income changes from month to month.
If you do not expect changes to 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.

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

Complete Step 2 for your spouse 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. For an adult to qualify for Adult Expansion Group, children in their care living in the same home must qualify for MO HealthNet or receive other Minimum Essential Coverage. Provide information on Step 3 regarding medical coverage for children in this person's care.

1. Legal Name (First name, Middle name, Last name, & Suffix)	2. OPTIONAL- Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Legally Separated ☐ Other	3. Relationship to you?
4. Date of birth (MM/DD/YYYY)	5. Sex: ☐ Male ☐ Female	6. OPTIONAL – Is this person a US Veteran? ☐ Yes ☐ No ☐ Prefer not to answer

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

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

9. What is this person's preferred language (if not English)?	10. How well does this person speak English? ☐ Very Well ☐ Well ☐ Not Well ☐ No Spoken Proficiency ☐ Prefer not to answer

11. ☐ Check here if this person is an American Indian or Alaska Native and fill out Appendix D.

12. ☐ Check here if this person needs help paying for medical bills for the 3 months prior to this application and fill out Appendix A.

13. **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 does not 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_____

14. **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 question 29.

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

16. Race (OPTIONAL – check all that apply.)

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

17. Is this person a US Citizen or US National? ☐ Yes ☐ No

18. Is this person a naturalized or derived US Citizen? (This usually means you were born outside the US.) ☐ Yes ☐ No
   Alien Number: _____ Certificate Number:_____

19. ☐ Check here if this person is not a US Citizen or US National, but has an eligible immigrant status. Provide the following information:
   Immigration Status Start Date: _____ Fill in the document type and ID Number below.
   a. Immigration document type _____ Document ID number _____
   b. Has this person lived in the US since 1996? ☐ Yes ☐ No
   c. Is this person or their spouse or parent a veteran or an active-duty member of the US Military? ☐ Yes ☐ No
   d. If this person has been in the US for less than 5 years, please enter their immigrant status (refugee, asylee, etc.) _____

20. ☐ Check here if this person is pregnant, or were recently pregnant. Provide the following information:
   How many babies are expected during this pregnancy? _____ What is this person's expected due date?_____
   If this person was recently pregnant, what was the date the pregnancy ended? _____

21. ☐ Check here if this person lives with at least one child under the age of 19, and is the main person taking care of this child.

22. ☐ Check here if this person is a full-time student in high school, equivalent vocational training, or technical training.
   Type of school (high school, college, etc.) _____

23. ☐ Check here if this person was in foster care at age 18 or older. What state were they in care? _____

24. ☐ Check here if this person is under age 19 and eligible to enroll in healthcare as part of a state employee benefit plan.

25. ☐ Check here if this person receives or is eligible to receive Medicare. When did this person become eligible? _____

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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 their income. Start with question 26.
☐ Self-employed - Skip to question 36.
☐ Not employed - Skip to question 37.

Current Job 1: ☐ Check here if taxes are not withheld from this income before they receive it.

26. Employer name and address

27. Employer phone number

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

29. Average hours worked each WEEK: _____

30. Job start date: _____

Current Job 2: ☐ Check here if taxes are not withheld from this income before they receive it.

31. Employer name and address

32. Employer phone number

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

34. Average hours worked each WEEK: _____

35. Job start date: _____

36. If self-employed, answer the following questions:
a. Type of work:
_____

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

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

38. **Other income this month**: Check all that apply, and give the amount and how often this person gets the income.

☐ None
☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Alimony received $_____ How often? _____
Date of order or last modification:_____/_____/_____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type _____

39. **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? _____
Date of order or last modification:_____/_____/_____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type: _____

40. 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.

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STEP 3: Your Family's Health Coverage

1. Do all children living with you (who are in your care) receive Minimum Essential Coverage (MEC) healthcare? ☐ Yes ☐ No

   If no, which children do not receive MEC? _____
   Examples of insurance plans that are considered MEC are MO HealthNet, Children's Health Insurance Plan (CHIP), Tricare, Medicare, coverage through a parent's employer, and private health plans.

2. Is anyone who is requesting healthcare now enrolled in health coverage from the following?

   ☐ **No**. If no, continue to #3. ☐ **Yes.** If yes, check the type of coverage and complete chart below.

☐ MO HealthNet ☐ Peace Corp ☐ VA Healthcare ☐ Employer Sponsored Insurance ☐ Tricare - Do not check if you have direct care for Line of Duty

☐ Medicare ☐ Other Health Insurance (explain):

Please complete the following information:

Policy Number / Medicare Claim Number:	Plan 1:	Plan 2:
Applicant(s):		
Policy Start Date:		
Group Name:		
Group Number:		
Insurance Company Name:		
Policy Holder Name:		
Policy Holder SSN:		
Policy Holder Date of Birth:		
Policy Holder Address:		
Policy Holder Date of Birth:		
Policy Holder Address:		

3. Does this health insurance cover the following: ☐prenatal care ☐labor/delivery ☐post-partum care

4. 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, you will also need to complete Appendix B.
   ☐ No, continue to Step 4.

STEP 4:

1. ☐ Check here if anyone on the application is in jail or prison. If so, who? _____
   When did they become incarcerated? _____

2. ☐ Check here if anyone applying for benefits in the household is blind. If so, who? _____
   OPTIONAL - Do you want to apply for Blind Pension or Supplemental Aid to the Blind (cash benefits)? ☐ No ☐ Yes

3. ☐ Check here if anyone applying for benefits in the household is disabled. If so, who? _____

4. ☐ Check here if anyone in the household applying for benefits has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.). If so, who? _____

5. ☐ Check here if anyone in the household applying for benefits lives in a medical facility, long-term care facility, or nursing home.
   a. If yes, who? _____
   b. Name of Facility _____
   c. Address of Facility _____

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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 authorize the Director of the Family Support Division or his/her appointee to investigate and verify these circumstances and statements through any means authorized by law, including accessing public and private databases.
- 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 whatsoever, in whole or in part, may subject me/us to criminal and/or civil prosecution.
- 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, automated phone calls and text messages regarding your case at the primary phone number you provided on page 1. You do not have to consent to this as a condition of eligibility. If you do not want to be contacted in this manner, you can opt out of getting these calls or messages.
  Check here: ☐ opt out calls ☐ opt out texts ☐ opt out calls and texts

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 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.

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.
☐ I agree to this statement.

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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 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 **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.**

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.

If signing electronically. By signing this application electronically, I certify under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my knowledge. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. ☐ I agree

Signature of applicant. 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.

Signature of Applicant	Date (mm/dd/yyyy)

Optional – Signature of Spouse or Second Parent

This is signature is optional to apply, but may be requested at a later time if certain applicants are requesting aged, blind, and disabled coverage. FSD needs permission to request any electronic verification records available from financial institutions, credit reporting bureaus and other agencies for the spouse, parent, stepparent, adoptive parent or other adult age 18 or older in the assistance group whose information counts towards program eligibility.

Signature of Spouse or Second Parent (OPTIONAL)	Date (mm/dd/yyyy)

STEP 6: Send your completed application.

Upload your document: Visit mydssupload.mo.gov to upload a copy of your document.

Mail to: Family Support Division
PO BOX 2700
Jefferson City, MO 65102

Fax to: (573) 526-9400

OPTIONAL – Have you or an immediate family member ever served in the US Armed Forces? ☐ Yes ☐ No

If YES, would you like information about military-related services in Missouri? ☐ Yes ☐ No

NEED HELP WITH YOUR APPLICATION? Visit mydss.mo.gov or call us at 855-373-9994. Para obtener una copia de este formulario en Español, llame 855-373-9994. TTY users call 800-735-2966

APPENDIX A

PRIOR QUARTER COVERAGE REQUEST: PERSON

(Please list additional individual as person 2, 3, 4 and so on)

Appendix A is OPTIONAL for your initial application for ongoing benefits. You can request prior quarter coverage up to 12 months after your initial application.

For faster service: Complete this form ONLY for persons who are requesting health coverage for the 3 months prior to this application.

1. Legal Name (First Name, Middle name, Last Name, & Suffix):
2. SSN or DCN:

3. For which months is this person requesting coverage? ☐ 3 months ago ☐ 2 months ago ☐ 1 month ago

4. For which months does this person have unpaid medical bills? ☐ 3 months ago ☐ 2 months ago ☐ 1 month ago

5. For which months was this person a resident of Missouri? ☐ 3 months ago ☐ 2 months ago ☐ 1 month ago

Income information

☐ Employed: If this person was employed in the 3 previous months, tell us about his/her income.	☐ Self-employed: Skip to question 12.	☐ Not Employed: Skip to question 13.

Job 1: ☐ Check here if taxes are not withheld from this income before this person receives it.

6. Employer name and address:
7. Employer phone number:

8. Wages/tips (before taxes) for each of the months coverage is being requested:

3 months ago $ _____ 2 months ago $_____ 1 month ago $_____

Job 2: ☐ Check here if taxes are not withheld from this income before this person receives it.

9. Employer name and address:
10. Employer phone number:

11. Wages/tips (before taxes) for each of the months coverage is being requested:

3 months ago $ _____ 2 months ago $_____ 1 month ago $_____

12. **If self-employed**, answer the following questions:

a. Type of work _____

b. How much net income (profits once business expenses were paid) did this person get from self-employment for each of the months coverage is being requested:

3 months ago $ _____ 2 months ago $_____ 1 month ago $_____

13. **Other income**: Check all that apply, and give the amount this person received for each month coverage is being requested.

		3 months ago	2 months ago	1 month ago
☐	None	N/A	N/A	N/A
☐	Unemployment			
☐	Pensions			
☐	Social Security			
☐	Retirement accounts			
☐	Alimony received			
☐	Net Farming/fishing			
☐	Net rental/royalty			
☐	Other income type			

14. **Deductions:** Check all that apply, and give the amount this person paid in deductions for each month coverage is being requested.

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 12b).

☐ Alimony Paid: 3 months ago $_____ 2 months ago $_____ 1 month ago $_____

☐ Student loan interest: 3 months ago $_____ 2 months ago $_____ 1 month ago $_____

☐ Other deductions: Type: _____

3 months ago $_____ 2 months ago $_____ 1 month ago $_____

Thanks! This is all we need to know about this person.

If you have more than two people to include, make a copy of this page to complete for each additional individual.

APPENDIX A

PRIOR QUARTER COVERAGE REQUEST: PERSON

(Please list additional individual as person 2, 3, 4 and so on)

Appendix A is OPTIONAL for your initial application for ongoing benefits. You can request prior quarter coverage up to 12 months after your initial application.

For faster service: Complete this form ONLY for persons who are requesting health coverage for the 3 months prior to this application.

1.	Legal Name (First Name, Middle name, Last Name, & Suffix):		2. SSN or DCN:	
3.	For which months is this person requesting coverage?	☐ 3 months ago	☐ 2 months ago	☐ 1 month ago
4.	For which months does this person have unpaid medical bills?	☐ 3 months ago	☐ 2 months ago	☐ 1 month ago
5.	For which months was this person a resident of Missouri?	☐ 3 months ago	☐ 2 months ago	☐ 1 month ago

Income information

☐ Employed:	☐ Self-employed:	☐ Not Employed:
If this person was employed in the 3 previous months, tell us about his/her income.	Skip to question 12.	Skip to question 13.

Job 1: ☐ Check here if taxes are not withheld from this income before you receive it.

6. Employer name and address:	7. Employer phone number:

8. Wages/tips (before taxes) for each of the months coverage is being requested:

3 months ago $_____ 2 months ago $_____ 1 month ago $_____

Job 2: ☐ Check here if taxes are not withheld from this income before you receive it.

9. Employer name and address:	10. Employer phone number:

11. Wages/tips (before taxes) for each of the months coverage is being requested:

3 months ago $_____ 2 months ago $_____ 1 month ago $_____

12. **If self-employed**, answer the following questions:
   a. Type of work _____
   b. How much net income (profits once business expenses were paid) did this person get from self-employment for each of the months coverage is being requested:
   3 months ago $_____ 2 months ago $_____ 1 month ago $_____

13. **OTHER INCOME**: Check all that apply, and give the amount this person received for each month coverage is being requested.

		3 months ago	2 months ago	1 month ago
☐	None	N/A	N/A	N/A
☐	Unemployment			
☐	Pensions			
☐	Social Security			
☐	Retirement accounts			
☐	Alimony received			
☐	Net Farming/fishing			
☐	Net rental/royalty			
☐	Other income type			

14. **DEDUCTIONS:** Check all that apply, and give the amount this person paid in deductions for each month coverage is being requested.

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 12b).

☐ Alimony Paid: 3 months ago $_____ 2 months ago $_____ 1 month ago $_____

☐ Student loan interest: 3 months ago $_____ 2 months ago $_____ 1 month ago $_____

☐ Other deductions: - Type: _____

3 months ago $_____ 2 months ago $_____ 1 month ago $_____

Thanks! This is all we need to know about this person.

If you have more than two people to include, make a copy of this page to complete for each additional individual.

APPENDIX B

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)

a. If you are in a waiting or probationary period, when can you enroll in coverage? _____ (MM/DD/YYYY)
List the names of anyone else who is eligible for coverage from this job.

Names: _____

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

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

14. Does this health insurance cover the following: ☐ prenatal care ☐ labor/delivery ☐ post-partum care

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

16. 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

17. 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
c. 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)

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix B 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 B. For Example, the answer to question 14 on this page should match question 14 on Appendix B.

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)

a. 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 this health insurance cover the following: ☐ prenatal care ☐ labor/delivery ☐ post-partum care

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

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

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

16. 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 premiums for this plan? **$** _____
b. 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.

17. 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
c. 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)

Missouri Department of Social Services
Family Support Division

APPENDIX C - Appointing a MO HealthNet Authorized Representative

Use this form if you would like to name someone to help you apply for MO HealthNet coverage and/or act on your behalf if you get MO HealthNet coverage. Family Support Division calls this person an authorized representative. You can choose to have an authorized representative or you can act on your own behalf. Even if you choose to have an authorized representative, FSD may sometimes need to contact you directly.

If you have a spouse, both you and your spouse can name the same authorized representative by listing both names in Section 1 and both signing in Section 2. If you do not list both names and both sign, the authorized representative will **ONLY be for the person whose name is listed and who signed**.

If you have a guardian and/or conservator, they must be the one to appoint an authorized representative. If you have an attorney-in-fact appointed by a valid Power of Attorney under Missouri law, they may appoint an authorized representative on your behalf, or you may appoint your own.

Instructions:

- Section 1: Fill out your information
- Section 2: Review the authorization information and sign your names.
- Section 3: Have the person, facility, or organization you are appointing fill out and sign their name to verify they accept the responsibilities listed below.
- Return the completed form to FSD **within 90 days** of the date(s) you and your authorized representative sign and date the form.

Section 1: Your information

Your name(s)	Date of birth or DCN
Home address	
Mailing address	
Email address	Phone number

I appoint as my/our authorized representative:

Name

My authorized representative is one or more of the following (check all that apply):

☐ Spouse	☐ Legal Guardian	☐ Attorney	☐ Public Administrator
☐ Department of Mental Health	☐ Conservator	☐ Power of Attorney	☐ None of these

I/we authorize this person or organization to be responsible to (check one or more boxes):

- ☐ Help me/us apply for MO HealthNet
- ☐ Act on my behalf if I/we get MO HealthNet, including annual renewals and reporting changes.
- ☐ Submit an application on my behalf, but have no other authority to act on my behalf or receive correspondence from FSD. This person is NOT allowed to receive my protected health information.
- ☐ Access FSD account online communications.
- ☐ Access FSD account online communications after my death.

Section 2: Your authorization to be represented

Based on your selections above, your authorized representative may receive notices and forms, information regarding all medical records in possession of FSD, including records containing information about specific diagnoses or diseases, sexually transmitted diseases, and mental health. This also includes drug/alcohol abuse and treatment information (per 42 CFR 2.31). You are consenting for your authorized representative to provide and receive protected health information (PHI).

The person or organization I/we have appointed is age 18 or older and knows my/our situation well enough that they can complete my/our application and act on my/our behalf. They will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation, or rule of this State or the United States.

Section 2: Your authorization to be represented (continued)	
I/we understand: • I/we am responsible for the information given by my/our authorized representative, including any information that may be incorrect. • This authorization is voluntary and can be cancelled at any time. I do not need to sign this form to receive FSD services. • I/we can request a copy of information disclosed to my authorized representative. • FSD has no control of the use of information after it is given to the authorized representative. If submitting electronically – I have agreed to submit this form by electronic means. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. ☐ I agree	
Signature:	Date:
Spouse or Second Parent's Signature:	Date
Section 3: Authorized representative agreement and acceptance	
Individual acting as authorized representative: fill out and sign this section.	
Representative's name	
Representative's mailing address	
Representative's email address	Representative's phone number
I am age 18 or older and know the participant's situation well enough to complete their application or act on their behalf. I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation, or rule of this State or the United States. I agree to be the applicant's authorized representative. I will protect the privacy of any information I get while acting as an authorized representative as required by Federal, State, and local laws, regulations, ordinances, and directives about privacy. If submitting electronically – I have agreed to submit this form by electronic means. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. ☐ I agree	
Authorized representative signature	Date
Individual acting as authorized representative for an organization or facility: fill out and sign this section.	
Organization or facility name	
Organization or facility address	
Organization or facility email	Organization phone number
• I represent the organization or facility named above. I have provided proof of my identity to FSD. • I have knowledge of the participant's situation well enough to complete their application or act on their behalf. • I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation, or rule of this State or the United States. • If I am authorized to only submit an application, I will not be authorized to act on their behalf and will not receive FSD correspondence. • I will report changes to FSD on behalf of the participant, as needed. I will inform FSD if I am no longer an authorized representative. I agree to be the participant's authorized representative. I will protect the privacy of any information I get while acting as an authorized representative as required by Federal, State, and local laws, regulations, ordinances, and directives about privacy. If submitting electronically – I have agreed to submit this form by electronic means. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. ☐ I agree	
Authorized representative signature	Date

APPENDIX D

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

Complete this appendix if you or a family member are an 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?_____