



Missouri Family Support Division

Date: _____

Name: _____ DCN : _____

Address: _____

City, State, Zip: _____

MO HealthNet Review Form

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 still qualify for MO HealthNet. Please help us by filling out this form. When answering the questions, please answer for every member of your household. If you don't have enough room to answer all of the questions, complete section E or attach additional 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.

After you fill out the form, please sign on the last page where it says "Signature/Affidavit/Mark." For MO HealthNet for Families, if both parents are in the home, both parents should sign this form.

Please send written proof of your household income when you return this form. Proof could include paycheck stubs for the last month or a letter from your employer. If you are self-employed, send a copy of your latest tax return or self-employment records for the past year.

IMPORTANT! Return this form by ** _____ ** to the address listed below. FSD will review it and call or send you a letter if more information is needed. Failure to return this form may result in your MO HealthNet coverage being closed.

FSD OFFICE: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

Need help with your review? Call us at 1-855-373-4636. If you need help in a language other than English, call 1-855-373-4636 and tell the customer service representative the language you need. TTY users should call 1-800-735-2966.

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.

MO HEALTHNET ELIGIBILITY REVIEW FORM	Complete and return by:
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SECTION A: Complete for all MO HealthNet Programs

Full Legal Name for Head of Eligibility Unit (First, Middle, Last)	DCN		
Street Address	City	State	Zip
Primary Phone number _____ What kind of phone is this? <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> other _____	Alternate Phone _____ What kind of phone is this? <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> other _____		
Email address	Preferred method of contact <input type="checkbox"/> *call <input type="checkbox"/> **text <input type="checkbox"/> email <input type="checkbox"/> mail <small>*we will call your primary phone unless you note otherwise. ** as capabilities allow</small>		

BELOW LIST ALL MEMBERS OF THE HOUSEHOLD. ATTACH ADDITIONAL PAGES IF NEEDED.

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

*1 White 2 Black/African American 3. Not used 4. American Indian/Alaska Native 5. Asian 6. Native Hawaiian/Pacific Islander 7. Chinese 8. Filipino 9. Japanese 10. Korean 11. Vietnamese 12. Other Asian 13. Guamanian or Chamorro 14. Samoan 15. Other 16. I prefer not to answer at this time

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 If Yes, Who? _____

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

Client Name _____

Client DCN _____

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*	CHECK DATE	START DATE	MONTHLY GROSS INCOME	TIPS, or MISC.

*Hour Day Week Every two weeks Twice monthly Month Year

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? _____

Client Name _____

Client DCN _____

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		
Any other income Explain:			Any other income Explain:		

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

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

Client Name _____

Client DCN _____

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: _____

Child: _____ Absent Parent: _____

Do you have any new information about an absent parent(s)? Yes No

SECTION C: Complete for Uninsured Women's Health Services

Is health insurance available for any female member of your family, ages 18 up to 56 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 56 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

Are you, any woman in your household, or any woman you are claiming as a tax dependent between the ages of 18 up to 56 in need of family planning services? Yes No

If yes, who? _____

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.

Client Name _____

Client DCN _____

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 (HIPPP) 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 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.
- I/we agree that by 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.
- By signing this application on paper or electronically, you are giving us permission to deliver, or cause to be delivered, phone calls to you regarding your case from an automated dialing system at the primary phone number you provided on page 2. You do not have to consent to this as a part of your application. If you want to opt out of getting these calls, check here:

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:** _____

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.**)
