**IM-1UA Application Supplement**

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|  | Answer these questions in order to determine your eligibility for MO HealthNet afterJanuary 1, 2014. |  |
|  |  |  |
|  | If you wish to receive email about this application after January 1, 2014, please provide  |  |
|  | an email address: |       |  |
|  |  |  |
|  | Do you plan to file a federal income tax return NEXT YEAR? [ ]  Yes [ ]  No |  |
|  | If yes, please answer the questions below: |  |
|  | Will you file jointly with a spouse? [ ]  Yes [ ]  No | If yes, name of spouse: |        |  |
|  | Please list any dependents you will claim on your return:  |       |  |
|  |        |  |
|  | Will you be claimed as a dependent on someone else's tax return: [ ]  Yes [ ]  No  |  |
|  | If yes, please list the name of the tax filer:  |         |  |
|  |       |  |
|  | If anyone in the household is pregnant, please list their name and how many babies they  |  |
|  | are expecting: |        |  |
|  | Please list the name of any full-time students: |        |  |
|  |        |  |
|  | Please list the name of anyone in the household who was in foster care at the age of 18 or older: |  |
|  |        |  |
|  | If anyone in the household is employed please list their name and their employer’s phone  |  |
|  | number: |        |  |
|  |        |  |
|  | Please check any personal deductions that you claim on your federal tax return: |  |
|  | [ ]  Alimony Paid | $       | How often? |   |  |
|  | [ ]  Student loan Interest | $       | How often? |   |  |
|  | [ ]  Other Deductions |  |  |  |  |  |
|  | Type: |        |  | $       | How often? |   |  |
|  | Type: |        |  | $       | How often? |   |  |
|  | Type: |        |  | $       | How often? |   |  |
|  |  |  |
|  | If your income changes from month to month, what is your total income this year? | $       |  |
|  | What do you think your total income will be next year? | $       |  |
|  | Is anyone in the home an American Indian or Alaskan Native? [ ]  Yes [ ]  No |  |
|  | If yes, are they a member of a federally recognized tribe? [ ]  Yes [ ]  No |  |
|  | If yes, please list the member and tribe name: |        |  |
|  |        |  |
|  | Are they 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  |  |
|  | Certain monies received by federally recognized tribes may not be counted for MO HealthNet. List any income reported on your application that includes money from tribes, natural resources, royalties, money from selling things that have cultural significance:  |  |
|  | Type: |        |  | $       | How often? |   |  |
|  | Type: |        |  | $       | How often? |   |  |
|  | Type: |        |  | $       | How often? |   |  |
|  |  |  |
|  | • I am signing this application supplement 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 and or untrue information. • I know that I must tell the Family Support Division if anything changes (and is different than) what I wrote on this application supplement. I can visit **my.dss.mo.gov** or call **1-855-373-9994** 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**](http://dss.mo.gov/files/missouri-nondiscrimination-policy-statement.htm) |  |
|  | • I confirm that no one applying for health insurance on this application supplement is incarcerated  |  |
|  |  (detained or jailed).  |  |
|  | 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. **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. **If anyone on this application supplement 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. **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 **1-855-373-9994**. 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. **Sign this supplement.** The person who filled out the application should sign this supplement. If you are an authorized representative, you may sign here, as long as you have provided the information required in Appendix C of the IM-1SSL. |  |
|  | Signature | Date (mm/dd/yyyy) |  |
|  |  |  |  |