MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MO HEALTHNET ADD A PERSON

Missouri Department of Social Services

Head of Household:	Head of Household's DCN/SSN:
Phone Number:	Email Address:
Street Address:	
Mailing Address:	

Complete this form for each person you are adding to your case, which may include your spouse/partner, children who live with you, and/or anyone on your same federal income tax return, if you file one. If you do not file a tax return, remember to 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.

1. Legal Name (First, Middle, Last, & 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. We may need additional information.

12. ☐ Check here if this person needs help paying for medical bills for the 3 months prior to this request. We may need additional information.

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 27.

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? _____

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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? _____

26. ☐ Check here if this person has a physical, mental, or emotional health condition that causes limitations on activities (like bathing, dressing, daily chores, etc.). If so, who? _____

Current Job & Income information

☐ Employed - If this person is currently employed, tell us about their income. Start with question 27.
☐ Self-employed - Skip to question 37.
☐ Not employed - Skip to question 38.

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

27. Employer name and address

28. Employer phone number

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

30. Average hours worked each WEEK:

31. Job start date:

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

32. Employer name and address

33. Employer phone number

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

35. Average hours worked each WEEK:

36. Job start date:

37. **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?
$ _____

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

39. **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 _____

40. **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 38b).

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

41. **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 household members to include, complete for each additional individual.

SAVE PRINT RESET