MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
SUSPENDING INCARCERATED PARTICIPANTS

Missouri Department of Social Services

Participants who were receiving MO HealthNet (MHN) before incarceration, or who are approved for MHN after they become incarcerated, must be suspended. Suspension prevents MHN from being used and medical claims from being paid while the participant remains in a corrections facility, jail, or prison. A suspended participant does NOT have to complete a new application for an inpatient event, or when released from incarceration.

Instructions: Use this Suspending Incarcerated Participants (IM-150) form to report a MHN participant is incarcerated. This may be completed by the facility contact person, the participant, a household member, or an authorized representative.

Incarcerated Participant

Participant's Name:			
SSN:		DCN:	
Date of Birth:		DOC/Offender ID (if applicable):	

Are the participant's MHN benefits active?
Benefits are active if you were receiving MO HealthNet benefits before becoming incarcerated.

☐ Yes, MHN benefits are active and need to be suspended. Complete this form and submit to MHNJailsandDOCReport@ip.sp.mo.gov.

☐ No, the participant is not receiving MHN and wants to apply.
This form is **optional** for new applicants, but may provide information for FSD to correctly approve, suspend, and later restore MHN benefits when an applicant is incarcerated.

Submit this form to FSD.SuspendedDOC@dss.mo.gov. If you complete a paper application, return this form with the application. If you complete an online or phone application, you may submit this form separately.

Date application was submitted: _____

Application was submitted by:

☐ Online application	https://mydss.mo.gov/healthcare/apply
☐ Phone application	855-373-9994
☐ Paper application	Application for Health Coverage & Help Paying Costs (IM-1SSL)

Incarceration Information

Date of Incarceration: (first date of continuous incarceration)	
Expected release date (if known):	
Facility name:	
Address:	
Were you transferred to this facility from another facility? What facility?	

Is a transfer to another facility expected? What facility?	
Expected transfer date (if known):	

Any other information or changes that you need to report
Completed by:

Name:			
Relationship to Participant:		Email:	
Phone:		Date Completed:	

SAVE PRINT RESET