



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 [FSD.IM.SuspendedMHNDOC@dss.mo.gov](mailto:FSD.IM.SuspendedMHNDOC@dss.mo.gov).

No, the participant is not receiving MHN but has applied.

This form is **optional** for new applicants, but may provide information for FSD to correctly approve, suspend, and later restore MHN benefits.

Submit this form to [FSD.IM.SuspendedMHNDOC@dss.mo.gov](mailto:FSD.IM.SuspendedMHNDOC@dss.mo.gov). Submit your application online or by following the instructions on the application.

Date application was submitted: \_\_\_\_\_

Application was submitted:

- 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:<br>(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: |  |