MISSOURI DEPARTMENT OF SOCIAL SERVICES FAMILY SUPPORT DIVISION

**INPATIENT COVERAGE FOR INCARCERATED PARTICIPANTS**

Missouri Department of Social Services

Incarcerated participants who leave state or local facilities for at least 24 hours to receive treatment in local hospitals may be covered by MO HealthNet (MHN), if otherwise eligible. Participants who were receiving MO HealthNet (MHN) before incarceration, or who are approved for MHN after they become incarcerated, must be suspended. A suspended participant does NOT have to complete a new application for an inpatient event.

**Instructions:** Use this Inpatient Coverage for Incarcerated Participants (IM-151) form to request restored benefits for inpatient care. This may be completed by the facility contact person, the participant, a household member, or an authorized representative. Additional verification may be requested before FSD approves coverage.

**NOTE:** A separate IM-151 is required for each inpatient event. Example: Cory was admitted to ABC Hospital for care September 1 through September 4. He returned to DOC and then was admitted to ABC Hospital again on September 10 through September 15. Two separate IM-151 forms are required.

## Incarcerated Participant

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

**Are the participant's MHN benefits suspended?**
Benefits are suspended if they were receiving MHN before becoming incarcerated, or if they have been approved since being incarcerated.

☐ Yes, benefits are suspended.
Complete this form and submit to FSD.SuspendedDOC@dss.mo.gov.

☐ No, the participant does not currently have MHN benefits.
Complete this form and submit it to FSD.SuspendedDOC@dss.mo.gov AND complete an application for MO HealthNet.

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) |

## Correctional Facility

| | | | |
|---|---|---|---|
| Facility name: | | | |
| Address: | | | |
| Contact person: | | | |
| Phone: | | Email: | |

| Inpatient Event | | | |
|---|---|---|---|
| Medical Facility: | | | |
| Address: | | | |
| Admit date: | | Discharge date: | |
| Reason for stay: | | | |
| Any other information or changes that you need to report | | | |
| | | | |
| | | | |
| Completed by | | | |
| Name: | | | |
| Relationship to Participant: | | Email: | |
| Phone: | | Date Completed: | |

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