MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
ONGOING COVERAGE SIGNATURE REQUEST

Case Name:	DCN:	Date:

Instructions: Use this form when an active MO HealthNet participant, who is not the head of household, needs to create a new case due to moving out of the existing household or changes in tax filing status.

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. Add more pages if necessary.

Note: You do not need to file taxes to get health coverage.

For adults who need coverage:	For children under age 19 who need coverage:
Include these people even if they aren't applying for health coverage for themselves: • Any spouse they live with • Any child under age 19 they live with, including stepchildren • Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return).	Include these people even if they aren't applying for health coverage themselves: • Any parent (or stepparent) they live with • Any sibling they live with • Any child they live with, including stepchildren • Any spouse they live with • Any other person on the same federal income tax return.

Household Member 1 (Yourself): _____

Date of Birth: _____ **Social Security Number: _____

Will **you** file income taxes next year? _____

Household Member 2: _____

Date of Birth: _____ **Social Security Number: _____

Relationship to you: _____ Will this person file taxes next year? _____

Will you claim this person as a dependent on income taxes next year? _____

Household Member 3: _____

Date of Birth: _____ **Social Security Number: _____

Relationship to you: _____ Will this person file taxes next year? _____

Will you claim this person as a dependent on income taxes next year? _____

Household Member 4: _____

Date of Birth: _____ **Social Security Number: _____

Relationship to you: _____ Will this person file taxes next year? _____

Will you claim this person as a dependent on income taxes next year? _____

****We need this if you want health coverage and have a Social Security Number (SSN).** Providing your SSN can be helpful if you do not want health coverage too since it can speed up the eligibility process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting a SSN, call 800-772-1213 or visit socialsecurity.gov. TTY users should call 800-325-0778.

Read & sign

MO HealthNet Rights and Responsibilities
PLEASE READ CAREFULLY AND SIGN BELOW

- I/we agree to provide Social Security Numbers of all persons applying for MO HealthNet as required by law. The Social Security Number is used to determine eligibility and verify information.
- I/we agree to be evaluated for the Health Insurance Premium Payment Program (HIPP) if I or members of the household are employed or lost employment in the last 30 days and the employer or former employer offers group health insurance.
- I/we authorize the Director of the Family Support Division or his/her appointee to investigate and verify these circumstances and statements through any means authorized by law, including accessing public and private databases.
- I/we will report any changes in circumstances within TEN DAYS of when they happen.
- I/we know it is against the law to obtain or attempt to obtain benefits to which I am/we are not entitled. Any false claim, statement, or concealment of any material fact whatsoever, in whole or in part, may subject me/us to criminal and/or civil prosecution.
- I/we understand acceptance of MO HealthNet constitutes an assignment of rights to the Department of Social Services, MO HealthNet Division for payment for medical care from a third party.
- I/we agree that medical information about me and/or my family can be released if needed for treatment, payment of medical expenses, health care operations, and/or to administer this program.
- If I am/we are found to be eligible for MO HealthNet I/we know the state of Missouri will pay for covered services on my/our behalf and agree the state may file a claim against my/our estate to recover any assistance received.
- By signing this form on paper or electronically, you are giving us permission to deliver, or cause to be delivered, automated phone calls and text messages regarding your case at the primary phone number you provided on page 1. You do not have to consent to this as a condition of eligibility. If you do not want to be contacted in this manner, you can opt out of getting these calls or messages. Check here: ☐ opt out calls ☐ opt out texts ☐ opt out calls and texts

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 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.

If anyone on this form 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 form 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.
☐ I agree to this statement.

Read & sign, continued

I am signing this form 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 or untrue information.

- I know that I must tell the Family Support Division if anything changes (is different than what I wrote on this form). I can visit **mydss.mo.gov** or call **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.

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.

If signing electronically. By signing this form electronically, I certify under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my knowledge. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. ☐ I agree

Signature of applicant. The person who is listed as Household Member 1 should sign this form. If you are an authorized representative, you may sign here, as long as you have provided proof that you are authorized to apply for this person.

Signature of Applicant	Date (mm/dd/yyyy)

Optional – Signature of Spouse or Second Parent

This is signature is optional to apply, but may be requested at a later time if certain applicants are requesting aged, blind, and disabled coverage. FSD needs permission to request any electronic verification records available from financial institutions, credit reporting bureaus and other agencies for the spouse, parent, stepparent, adoptive parent or other adult age 18 or older in the assistance group whose information counts towards program eligibility.

Signature of Spouse or Second Parent (OPTIONAL)	Date (mm/dd/yyyy)

Send FSD your completed form.

Upload your document: Visit mydssupload.mo.gov to upload a copy of your document.

Mail to: Family Support Division

PO BOX 2700

Jefferson City, MO 65102

Fax to: (573) 526-9400

OPTIONAL – Have you or an immediate family member ever served in the US Armed Forces? ☐ Yes ☐ No

If YES, would you like information about military-related services in Missouri? ☐ Yes ☐ No

NEED HELP? Visit mydss.mo.gov or call us at 855-373-9994.

Para obtener una copia de este formulario en Español, llame 855-373-9994.

TTY users call 800-735-2966.

SAVE PRINT RESET