Save Print Reset

STEP 1: Household Members - ongoing coverage signature request.

Please complete the following for your additional household member living with you:

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. (You do not need to file taxes to get health coverage).

DO Include:

- Yourself (Applicant)
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- The parent of any child who needs health coverage
- Anyone you include on your tax return, even if they do not live with you
- Anyone else under 21 who you take care of and lives with you

You DO NOT have to include:

- Your unmarried partner who does not need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you are over 21)
- Other adult relatives who file their own tax return

How will **you** file income taxes next year? _____

Household Member 1: _____

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

Relationship to you: _____ Tax Filing Status: _____

How will **you** file income taxes next year?

Household Member 2: _____

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

Relationship to you: _____ Tax Filing Status: _____

How will **you** file income taxes next year?

Household Member 3: _____

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

Relationship to you: _____ Tax Filing Status: _____

How will **you** file income taxes next year?

Household Member 4: _____

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

Relationship to you: _____ Tax Filing Status: _____

****We need this if you want health coverage and have an SSN**. Providing your SSN can be helpful if you do not want health coverage too since it can speed up the application 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 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

NEED HELP WITH YOUR APPLICATION? Visit **mydss.mo.gov** or call us at **1-855-373-9994**. Para obtener una copia de este formulario en Español, llame **1-855-373-9994**. TTY users call 1-800-735-2966

STEP 2: Read & sign this ongoing coverage signature request.

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 agree that statements and information provided may be verified.

• 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 whatever, in whole or in part, may subject me/us to criminal and/or civil prosecution.

• I/we agree that by being determined eligible for MO HealthNet for a child who is deprived of parental support, I/we have assigned all rights to medical support to the State of Missouri, and that I/we must cooperate in establishing paternity and obtaining medical support, unless I/we have good cause. Failure to cooperate does not affect a child's eligibility.

• I/we understand healthcare benefits based on a person being age 65 and over, blind or disabled is not determined by completing this ongoing coverage signature request. For healthcare benefits explored on the basis of being age 65 or over, blind or disabled, I/we must complete a different application for these benefits.

• 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 ongoing coverage signature request on paper or electronically, you are giving us permission to deliver, or cause to be delivered, phone calls to you regarding your case from an automated dialing system at the primary phone number you provided on page 2. You do not have to consent to this as a part of your ongoing coverage signature request. If you want to opt out of getting these calls, check here: ☐

If anyone on this application 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 in your household 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.

Continue on next page

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STEP 2: Read & sign this ongoing coverage signature request continued

I am signing this ongoing coverage signature request 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 and or untrue information.

- I know that I must tell the Family Support Division if anything changes (is different than what I wrote on this ongoing coverage signature request). I can visit **mydss.mo.gov** or call **1-855-373-9994** 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.**
- Is anyone applying for health insurance on this signature request incarcerated (detained or jailed).

  Yes ☐ No ☐

  If yes, write the name of the person here:_____.
  ☐ Check here if this person is pending disposition of charges.

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.

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 **1-855-373-9994**. 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.

Sign this ex-parte signature request. The person who filled out step 1 should sign this ex-parte signature request. If you are an authorized representative, you may sign here, as long as you have provided the information required in Appendix C or the IM Authorized Representative Form (IM-6AR).

SIGN HERE

Signature of Applicant	Date (mm/dd/yyyy)

STEP 3: Mail completed ongoing coverage signature request.

Email or mail your signed ongoing coverage signature request (include all pages) to:

FSD.Documents@dss.mo.gov

FSD Application Processing Center
PO BOX 1353
Joplin, MO 64802

If you want to register to vote, you can complete a voter registration form at:
http://sos.mo.gov/elections/goVoteMissouri/register.aspx