



Dear Parent/Guardian:

Your child may be eligible for affordable health insurance through the MO HealthNet for Kids (MHK), Missouri's Health Insurance Program. Now most families can get low-cost or free health insurance for their children.

Children with health insurance are more likely to receive needed vaccinations and receive treatment for illnesses. Without treatment, these illnesses can slow a child's learning and have lifelong effects.

If you currently receive MO HealthNet for Kids (formerly MC+ for Kids), it is not necessary to complete the attached application. Current participants can contact their local county Family Support Division office for questions regarding healthcare coverage.

If you are interested in applying for MHK, please complete the enclosed application and mail to:

MO HealthNet Service Center  
 525 Jules St. #127  
 St. Joseph, MO 64501

**HAVE QUESTIONS OR NEED HELP COMPLETING ATTACHED APPLICATION  
 DIAL 1-888-275-5908**

**MO HealthNet for Kids - Missouri's Health Insurance Program**

**Do Your Children Qualify?**

	Maximum MONTHLY Family Income			
FAMILY SIZE <small>(Includes parents)</small>	2	3	4	5
INCOME <small>(Subject to change annually)</small>	\$3,643	\$4,578	\$5,513	\$6,448
<b>Some families may be required to pay premiums. Income standards effective April 1, 2009</b>				
Families that are larger than five can dial <b>1-888-275-5908</b> for income limits.				

Do your children need health care coverage? MO HealthNet for Kids is Missouri's health insurance program for uninsured children.

**MO HEALTHNET FOR KIDS**

**COMPLETE IN INK**

A. MAILING ADDRESS			FOR OFFICE USE ONLY
NAME (FIRST, MIDDLE, LAST)			DATE APPLIED
ADDRESS (HOUSE NO., STREET OR RURAL ROUTE, P.O. BOX NO.)	CITY, STATE, ZIP CODE	COUNTY	DCN
HOME PHONE NUMBER - -	WORK PHONE NUMBER - -	MESSAGE PHONE NUMBER - -	ELIGIBILITY SPECIALIST/SUPV/LOAD / /

**INSTRUCTIONS: Please answer each question completely. Attach an additional sheet if more space is needed in any section.**

**B. HOUSEHOLD INFORMATION  
(LIST ALL CHILDREN, PARENTS/GUARDIANS AND STEPPARENTS WHO LIVE IN YOUR HOME, YOURSELF FIRST.)**

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	RACE*/ SEX	HISPANIC Y/N	RELATIONSHIP TO PERSON a.	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	(X) APPLYING FOR MHK
a.			SELF			- -	<input type="checkbox"/>
b.						- -	<input type="checkbox"/>
c.						- -	<input type="checkbox"/>
d.						- -	<input type="checkbox"/>
e.						- -	<input type="checkbox"/>
f.						- -	<input type="checkbox"/>

\*(1 - WHITE    2 - BLACK/AFRICAN AMERICAN    4 - AMERICAN INDIAN/ALASKAN NATIVE    5 - ASIAN    6 - NATIVE HAWAIIAN/PACIFIC ISLANDER)

1. Are both parents of all the children in the home?     YES     NO    (If NO, complete section E.)
2. Are all of the persons applying for MHK U.S. citizens?  YES     NO    If NO, list the following information for persons applying for MHK who are not U.S. citizens: Name, immigration status and registration number, date of entry: \_\_\_\_\_
3. You may qualify for coverage of unpaid bills for medical services received in the past three months. Did any of the persons listed above receive medical services in the past three months?  YES     NO    If yes, who? \_\_\_\_\_
4. Is anyone in your household pregnant?     YES     NO    If yes, who? \_\_\_\_\_ Expected due date? \_\_\_\_\_
5. Is your net worth (net worth is the value of everything you own minus any debt.):  less than \$50,000     \$50,000-\$100,000  
 \$100,000-\$150,000     \$150,000-\$200,000     \$200,000-\$250,000     above \$250,000  
 Please list your assets (bank accounts, stocks/bonds, vehicles, home, real and personal property, etc.) \_\_\_\_\_

**C. INCOME (Please attach verification; i.e. paycheck stub, note from employer, federal income tax return, award letter, etc.)**

1. Are you employed?     YES     NO    If YES, name of employer \_\_\_\_\_  
 How much are you paid **before** taxes or deductions? \_\_\_\_\_  Weekly     Every two weeks     Twice monthly     Monthly
2. Is anyone else in your home employed?     YES     NO    If yes, who? \_\_\_\_\_  
 Name of employer \_\_\_\_\_  
 How much are they paid **before** taxes or deductions? \_\_\_\_\_  Weekly     Every two weeks     Twice monthly     Monthly
3. Does anyone in your home operate their own business or are they otherwise self-employed?     YES     NO  
 If yes, who? \_\_\_\_\_ Describe what type of self-employment (baby-sitting, farm income, other) and amount earned: \_\_\_\_\_  Weekly     Monthly     Yearly
4. Childcare costs may be an allowable income deduction for working families. Do you pay someone to care for your child?  
 YES     NO    If yes, list names of children cared for: \_\_\_\_\_  
 How much do you pay for child care? \_\_\_\_\_  Weekly     Every two weeks     Twice monthly     Monthly

5. Does anyone in your home receive other income such as child support, alimony, Unemployment Compensation benefits, sick benefits, interest income, Social Security benefits, or other unearned income.  YES  NO If yes, complete the following:

PERSON RECEIVING	WHO PROVIDES THE MONEY?	AMOUNT RECEIVED?	HOW OFTEN RECEIVED?

**D. HEALTH INSURANCE**

1. Does anyone in your home have medical, hospital insurance or Medicare?  YES  NO

PERSONS INSURED	NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
		<input type="checkbox"/> Doctor <input type="checkbox"/> Hospital If limited coverage explain: _____
		<input type="checkbox"/> Doctor <input type="checkbox"/> Hospital If limited coverage explain: _____

2. Has anyone in your home lost or dropped health insurance within the past six months?  YES  NO If yes, provide name(s), date and reason coverage ended. \_\_\_\_\_

3. Is health insurance available for any member of your family through an employer or other group membership?  YES  NO

If yes, name of employer or group: \_\_\_\_\_  
 Is the insurance available for:  Self  Spouse  Children How much is the premium for the children? \$ \_\_\_\_\_ per \_\_\_\_\_

4. Do any of your children have a medical condition that left untreated would result in death or serious physical injury of the child?

YES  NO If yes, provide name(s) of child(ren) \_\_\_\_\_

5. Is a third party responsible to pay for any of your medical care?  YES  NO If yes, who? \_\_\_\_\_

6. Please refer to the income guidelines sent with the application. If income and family size fall in the premium group, submit 2 quotes from private insurance companies of what they would charge for medical coverage for all of your children.

1. \$ \_\_\_\_\_ per mo. Company \_\_\_\_\_ 2. \$ \_\_\_\_\_ per mo. Company \_\_\_\_\_

**E. ABSENT PARENT INFORMATION (Complete this section if a parent of any of the children is absent from the home.)**

NAME (FIRST, MIDDLE, LAST)	(MAIDEN)	RACE/SEX	SOCIAL SECURITY NUMBER	BIRTHDATE	PARENT OF WHICH CHILD?	LAST KNOWN ADDRESS
			- -			
			- -			

Do you have a good reason for not cooperating in obtaining support for medical care?  YES  NO If yes, please explain. \_\_\_\_\_

**F. PLEASE READ CAREFULLY AND SIGN BELOW.**

- I/We agree that I/we must provide Social Security Numbers of all persons applying for MHK as required by law. The Social Security Number is used to determine eligibility and verify information.
- I/we agree I/we must 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 my/our 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 that 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 applying for (and being determined eligible for) MHK 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 application. If I/we want eligibility 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 agree that medical information about me and/or my family can be released if needed to administer this program.
- Provided I am/we are found to be eligible for MHK I/we know the State of Missouri will pay for covered services on myour behalf and agree the state may collect payments from any third party (i.e., insurance, estate, etc.) for services paid by the state.

My/Our signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my/our knowledge. I/we authorize insurers or employers to release any information on myself or my/our dependent(s) needed to determine eligibility for the HIPP program.

SIGNATURE/AFFIDAVIT	DATE	SIGNATURE OF SPOUSE/AFFIDAVIT	DATE
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