

ENTITY ELIGIBILITY QUESTIONNAIRE

Name of Public Entity: _____

In order to assist us in determining if your entity meets the requirements of RSMo.103.003 and therefore eligible to participate in the Missouri Consolidated Health Care Plan, please complete this questionnaire and submit the requested information. Additional pages may be attached if necessary.

1. Was your entity created by:

- State statute? *Chapter & Section:* _____
- Local ordinance or order? *Please provide a certified copy of the ordinance order.*
- Other? *Please provide a copy of any documentation describing how your entity was created.*

2. How is your entity funded?

- Direct Tax Support? *Please describe this support. Is it state or local taxes?*

- Indirect tax support? *Please describe how these funds flow to your entity.*

3. Who is responsible for and controls the operations of your entity?

4. How is the body described in No. 3 selected?

- Elected
- Appointed. Who appoints? _____

Return this form with appropriate documents to:

Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110
Attention: Marketing
Fax: 573.526.3195

Determination may take up to 2 weeks.