MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

NOTIFICATION OF SPENDDOWN COVERAGE

FROM	**CASEWORKER**	**TELEPHONE NUMBER**	**DATE**
	COUNTY OFFICE ADDRESS (STREET)		
	(CITY, STATE, ZIP CODE)		
TO	NAME		
	ADDRESS (STREET)		
	CITY	STATE	ZIP CODE
RE	CASE NAME Medicaid Number	ELIGIBLE SPOUSE Medicaid Number	

This is to advise you that you (and your spouse if listed above) have met spenddown for the months listed below. Medicaid will not pay for any bills or portion of bills that go toward your spenddown amount. At least part of your spenddown amount has been met on the date your Medicaid started. The portion of your spenddown amount that was met on your Medicaid Start Date will be deducted from bills your provider sends to Medicaid for that date.

MONTH	MEDICAID START DATE	MONTHLY SPENDDOWN	AMOUNT OF SPENDDOWN MET ON START DATE

If you do not agree with this decision, you have the right to ask for a hearing within 90 days of the date of this letter. To request a hearing, call the local Division of Family Services office. If you request a hearing, we will schedule it for you and notify you of the time of the hearing. At the hearing, you may present your information yourself or may ask anyone else to assist you. You have the right to present witnesses in your behalf and to question witnesses who appear at the request of the Division of Family Services. To see if you can get free legal service call _____.

If your situation changes it is your responsibility under the law to report these changes at once to your local DFS office. The law provides penalties for any persons who receive benefits to which they are not entitled through misrepresenting the facts or not reporting full information about their situation.

CASEWORKER	LOAD