

MISSOURI DEPARTMENT OF SOCIAL SERVICES

FAMILY SUPPORT DIVISION

**NOTICE OF CASE ACTION FOR HOME AND**

**COMMUNITY BASED SERVICES WAIVER**

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| --- | --- | --- | --- |
| FROM: | OFFICE      | TELEPHONE NUMBER   -   -     | DATEToday’s date. |
|  | ADDRESS (STREET, CITY, STATE, ZIP CODE)       |
| TO: | NAME      |  | PARTICIPANT’S NAME      |
|  | ADDRESS (STREET)      |  | DCN      |
|  | CITY      | STATE   | ZIP CODE      |  |  |
| The following action was taken on your request for Home and Community Based Services (HCB) Waiver: |
| [ ]  | Your request for HCB has been rejected. |
|  |
| [ ]  | Your request for HCB was approved effective Date. |
|  |
| [ ]  | Your Qualified Income Trust was verified and meets the requirements.  |
|  |
| [ ]  | Your income has changed. Effective Date, you must change the amount you deposit into your Qualified Income Trust account each month. |
|  |
| [ ]  | You are required to deposit Diversion Amount in the trust account to remain eligible. See the below to see how we calculated this amount.  |
|  |  |
| [ ]  | Other:       |
|  |
| The action was taken because:       |
|  |
| Qualified Income Trusts - Gross Monthly Income and Trust Diversion Amount |
| Source of Income |  | Gross Amount (before any deductions) |
|       |  | $ |       |
|       | + | $ |       |
|       | + | $ |       |
|       | + | $ |       |
|       | + | $ |       |
| Total Gross Monthly Income | = | $ |       |
| Deduction HCB Income Maximum (refer to Appendix J for current amount) | - | $ |       |
| Trust Diversion Amount | = | $ |       |
| The Trust Diversion Amount is the minimum that **must be deposited** into the trust account each month. |
|  |
| You must report any changes in your situation to the Family Support Division. The law has penalties for a person who receives benefits because they did not tell us all the facts, or because they did not report a change.If you seek medical coverage under another health insurance plan, such as a group plan offered by your employer, you may need a Certificate of Creditable Coverage showing when you were covered by MO HealthNet. The certificate may help prove you have met part or all of an exclusionary period for pre-existing conditions. You may request a certificate within 24 months of losing MO HealthNet benefits. You may request a certificate by calling the MO HealthNet Division, Recipient Services at 800-392-2161. |
| You have the right to ask for a hearing within 90 days of this Action Notice, if you think the department made a mistake about your benefit determination. A hearing is a meeting between you, a staff member from FSD, and a hearing officer. At the hearing, you can explain why you think we made a mistake.For written requests, describe the error that was made and include your DCN number.You can ask for a hearing:* By phone: Call the FSD Information Center at 855-373-4636
* By fax: Send your request to 573-526-4554
* By mail: Mail your request to the address at the top of this letter.
* By email: Email your request to IMHearing.FSD@dss.mo.gov
* In person: Visit your local FSD Resource Center to speak to the FSD team member.

To prepare for your hearing, you can:* Bring someone with you to the hearing, like a friend, relative, or lawyer (but you can also come by yourself).
* Bring documents or witnesses to show us where you think we made a mistake.
* Request free legal services by contacting Legal Aid at 800-444-0514.
* Once you ask for a hearing, you will receive a notice in the mail with your hearing date.

You do not need to ask for a hearing if you agree with this decision. If you do not ask for a hearing, we will change your benefits on the above date. |
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