

MISSOURI DEPARTMENT OF SOCIAL SERVICES

FAMILY SUPPORT DIVISION

**NOTICE OF CASE ACTION FOR HOME AND**

**COMMUNITY BASED SERVICES WAIVER**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FROM: | | OFFICE | | | | TELEPHONE NUMBER     -   - | | | | DATE  Today’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](mailto: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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