MO HEALTHNET FOR FAMILIES ACTION NOTICE

PURPOSE: To provide a form to adequately notify participants that a change has been made in their MO HealthNet for Families or Transitional MO HealthNet benefits.

NUMBER OF COPIES AND DISPOSITION: One copy must be sent to the participant. If there is an Authorized Representative a second copy must be mailed to them. The original must be scanned into the WorkSite.

RETENTION: Five (5) years

REFERENCE: IM Memorandum: IM-68 Introduction of MAGI Notice of Case Action (IM-33 MAGI) Form 7/2/2015

INSTRUCTIONS FOR COMPLETION:

- **FROM** Name and address of FSD Team Member taking action.
- **TO** Head of Household (HOH) full name as shown in MEDES or name of Authorized Representative, Case Name, mailing address, and HOH DCN

- **WE HAVE TAKEN THE FOLLOWING ACTION(S) ON YOUR (select appropriate program) CASE:**

  OPTIONS: Read all options and determine which check boxes apply for a specific situation. There can be more than one check box marked.

  - **Your MO HealthNet application dated (**enter the application date**) has been rejected.**
  - **Your MO HealthNet review was completed and there are no changes to your benefits.**
  - **MO HealthNet benefits have been discontinued for the following person(s)** (list of household members affected)**. The last day of MO HealthNet coverage is (**date**).**
  - **MO HealthNet benefits have changed to (**program name**) effective (**date**) for the following persons: (**list household members affected**).**
  - **You are now required to pay a monthly premium to continue coverage for the following person: (**list of household members affected**).**
    You will receive an invoice informing you of the premium amount and the date payment is due.

- **The reason for this decision is:**

- o **your countable income of (**current household income according to MAGI methodology**) exceeds the maximum (**applicable income maximum for the family size**) for your household size of (**number of persons in the household**).**

- o **you did not return your first (1st) quarterly Transitional MO HealthNet Report.**

- o **your family no longer resides in Missouri.**

- o **you no longer have an eligible child living in the home, because such child either has left your household or has exceeded the MO HealthNet for Families age requirement.**

- o **we received your (**first, second, or third**) Transitional MO HealthNet report. Your current income of (**income amount**) exceeds the limit of (**appropriate income maximum**) to continue receiving coverage under this program.**

- o **Other (**If the reason for discontinuing benefits is not already listed, you may enter a reason here. You will need to enter a legal reference also.)

ADDITIONAL OPTIONS:

- o **Eligibility for health coverage has changed to Transitional MO HealthNet for the individuals listed above because of earnings from employment. There has been no change in your healthcare benefits for these individuals. Coverage will continue through (**date of the last day of the sixth month of TMH eligibility**). If you meet certain requirements, you may be eligible for an additional six months.**

- o **Your MO HealthNet for Families healthcare benefits have been reinstated effective (**date of reinstated coverage**) The reason for this action is: (**state reason**)**

- o **Due to the closing of your MO HealthNet for Families case an ex parte review was completed. The following changes in coverage were made: (**List each person whose coverage was changed followed by the change in coverage.**)**

- **For the possibility of free legal services call:** Enter the name and telephone number of the legal aid or legal services office for this person's county.