

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-64 ACTIVE MEDES CASES IDENTIFIED AT REPORTED CHANGE AS ELIGIBLE TRANSITIONAL MO HEALTHNET 11/03/2014

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 ON YOUR MO HEALTHNET FOR FAMILIES(MHF) CASE:** Read all options and determine which check boxes apply for a specific situation. There can be more than one check box marked.
- **Your application for MO HealthNet for Families has been rejected because (Blank):** State the reason for the rejection along with the appropriate legal citation.
- **MO HealthNet for Families (healthcare benefits) have been discontinued for the following persons:** List all persons being discontinued.
- **The last day of MO HealthNet coverage is:** Enter last day of coverage.
- **that your countable income of (blank):** Enter current household income according to MAGI methodology.
- **exceeds the maximum (blank):** Enter the MO HealthNet for Families income maximum for the family size.

- **for your household size of (blank):** Enter the number of persons in the household.
- **We received your (blank) Transitional MO HealthNet Report:**
Enter the number of the report: 1st, 2nd, or 3rd.
- **Your current income of (blank)**
Enter current household income according to MAGI methodology.
- **exceeds the limit of (blank) to continue receiving under this program.**
Enter the income maximum for the number of people in the household and according to the appropriate percentage level. (TMH Second and Third Quarterly Reports – 185% of the FPL)

EXAMPLE: Mary Jones handed in her 2nd TMH Quarterly Report. She has a household size of 3. You would enter 185% of the FPL for a household of 3 in this blank - \$3051.
- **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.
- **Coverage will continue through (blank)** Enter the date of the last day of the sixth month of TMH eligibility.
- **Your MO HealthNet for Families healthcare benefits have been reinstated effective (blank):** Enter date of reinstated coverage.
- **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.
- **FSD Team Member Name, Title, and Telephone Number:**
Enter whatever follows policy for your office.