MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

NOTICE OF POST ELIGIBILITY MEDICAL EXPENSE REDUCTION IN SURPLUS

FROM	FSD OFFICE NAME	TELEPHONE NUMBER	DATE January 30, 2020
	MAILING ADDRESS (NUMBER AND STREET, CITY, ZIP CODE)		
TO	NAME		CASE NUMBER
	ADDRESS (STREET)		
	CITY STATE ZIP CODE		
RE	VENDOR NAME		
	VENDOR NUMBER		

You have requested to have your monthly payment to the nursing home (surplus) temporarily reduced in order to pay for medical expenses that were incurred within the three months prior to the date of your MO HealthNet vendor coverage application and your approval. The purpose of the reduction in surplus amount is **only** to allow you to use your current month's income to pay for these previously incurred medical expenses.

☐ Your surplus is reduced to _____ for the months of _____ so that you can pay the provider to which you owe the qualifying medical expenses _____ per month during this time frame.

☐ The final month of your surplus reduction is a partial amount. For the month of _____ your surplus will be reduced to _____,

☐ The post eligibility medical expenses that were used to calculate the reduction in your surplus are listed below. You must pay the provider(s) directly.

_____

_____

☐ Due to a change to your income and/or expenses, beginning _____ your surplus is reduced to allow you to pay your provider _____ per month towards outstanding medical bills. Your surplus will be reduced through _____.

If the surplus is reduced to allow for payment of the expense, and you do not pay the provider for the outstanding balance, the surplus will not be reduced for that expense a second time.

In addition to the above amounts, the nursing home or institution may charge you or your relatives for services not covered by Medicaid.

Any increase, decrease, or other change in your income may change the amount you must pay to the nursing home or institution. Any increase in your resources may affect your eligibility. **You must report any change in your situation to your Family Support Division office immediately.** If you fail to give full information about your situation or if you receive benefits for which you are not eligible through misrepresentation, legal action can be taken against you.

If you feel this decision is not correct, you have the right to request a hearing within 90 days of the date of this letter.

If you wish to have a hearing, you may advise us of this by mail, by telephone, or in person. We will then schedule a hearing for you and notify you of the time of the hearing. If you request a hearing, you may present your information yourself or you may be represented by your own attorney or by other persons who have knowledge of your situation. If you do not have an attorney, cannot afford one, and live in an area served by a legal aid or legal services office, you may be eligible for this service. You have the right to present witnesses in your own behalf and to question witnesses who appear at the request of the Family Support Division.

FSD STAFF MEMBER	DATE

DETERMINATION OF MONTHLY PAYMENT TO NURSING HOME/INSTITUTION

GROSS MONTHLY INCOME

Social Security	
SSI	
VA	
Interest	
Earned	
Other	
TOTAL	

MONTHLY DEDUCTIONS

Personal Needs Allowance	
Medicare Premium	
Other Medical Insurance	
* Allotment for Spouse	
Allotment for other Dependents	
TOTAL	

* This is the amount you are currently giving your spouse. If your income increases, you may give your spouse up to _____ monthly.

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