MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

NOTICE OF DENIAL

FROM	**CASEWORKER**		**TELEPHONE NUMBER**	**DATE**
	COUNTY OFFICE ADDRESS (STREET, CITY, STATE, ZIP CODE)			
TO	NAME		**RE**	CASE NAME
	ADDRESS (STREET)			CASE NUMBER
	CITY	STATE / ZIP CODE		

Dear

We have reviewed your _____ application for health insurance through Missouri's MC+ program. Based on information you reported on the application, the following persons are not eligible for MC+:

_____

_____

You do not qualify because

You have the right to appeal decisions made involving your application. You can request a hearing within 90 days from the date of this letter, by calling _____ . 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 know your situation. You have the right to present witnesses in your behalf and to questions witnesses who appear at the request of the MC+ Service Representative. For the possibility of free legal services, call _____ .

Sincerely,

MC+ Service Representative

File No. _____