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

Your application for Medical Assistance has been approved on all points of eligibility except income for the following persons:

_____

Since your income is over the regular Medicaid limit, your coverage must be based on a "spenddown" (RSMo208.151). Spenddown is like a deductible on insurance policies, in that you and/or your spouse must be charged for medical care up to a certain dollar amount before your Medicaid coverage can begin. Please see the enclosed pamphlet for more information. Keep it for future reference.

Based on your income, your "spenddown" amount for the following months is:

_____

_____

You and/or your spouse must have medical care costs for a specific month to at least equal the spenddown amount for that month. We begin counting costs on the first day of the month and add your medical costs for each day. When the total of these costs equals or goes over your spenddown amount, you have "met spenddown" for that month.

Please provide copies of your paid and unpaid medical receipts, doctor bills, prescription charges, itemized hospital charges, and other medical care costs to me. I will determine which expenses can be used to meet your spenddown. If you are a Qualified Medicare Beneficiary (QMB) recipient, medical expenses covered by Medicare and QMB cannot be used to meet your spenddown.

Information may be on the back of this notice if you have already provided proof of countable medical costs for any of these months.

If you do not agree with this decision, you have the right to ask for a hearing within 90 days of the date of this letter. To request a hearing, call the local Division of Family Services office. If you request a hearing, we will schedule it for you and notify you of the time of the hearing. At the hearing, you may present your information yourself or may ask anyone else to assist you. You have the right to present witnesses in your behalf and to question witnesses who appear at the request of the Division of Family Services. To see if you can get free legal service call _____.

If your situation changes it is your responsibility under the law to report these changes at once to your local Division of Family Services office. The law provides penalties for any persons who receive benefits to which they are not entitled through misrepresenting the facts or not reporting full information about their situation.

ENCLOSURE: INFORMATION LEAFLET NO. _____	CASEWORKER SIGNATURE LOAD
IMPORTANT: THE BACK OF THIS FORM MAY CONTAIN INFORMATION ON YOUR MEDICAL COVERAGE	

You have provided proof of countable medical expenses for the following months that have not yet met your spenddown:

MONTH	SPENDDOWN AMOUNT	MEDICAL COSTS PROVIDED (total)	AMOUNT LEFT TO MEET SPENDDOWN

If you believe you have bills that have not been considered, please provide them to your worker.

For the current month and future months, you may begin your Medicaid coverage by paying your spenddown amount to the state. More information will be sent to you from Division of Medical Services very soon regarding this option.

You have provided medical expenses that meet your spenddown for the months listed below. You (and your spouse if listed on the front of this letter) are eligible for Medicaid from the start date listed through the end of that month. Medicaid will not pay for any bills or portion of bills that go toward your spenddown amount. At least part of your spenddown amount has been met on the date your Medicaid started. The portion of your spenddown amount that was met on your Medicaid Start Date will be deducted from bills your provider sends to Medicaid for that date.

MONTH	MEDICAID START DATE	MONTHLY SPENDDOWN	AMOUNT OF SPENDDOWN MET ON START DATE