

MISSOURI DEPARTMENT OF SOCIAL SERVICES

FAMILY SUPPORT DIVISION

**ADVERSE ACTION NOTICE**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FROM** | | | **Address (Street, City, State, Zip Code)**       ,       MO | | | | | | | | | | | | | | | | | | DATE  July 1, 2014 | | | |
| **TO** | | | NAME | | | | | | | | | | | | CASE NAME | | | | | | | | | |
|  | | | ADDRESS (STREET OR P.O. BOX NO.) | | | | | | | | | | | | CASE NUMBER | | | | | | | | | |
|  | | | CITY STATE ZIP | | | | | | | | | | | |  | | | | | | | | | |
| BASED ON THE INFORMATION WE HAVE ABOUT YOUR ELIGIBILITY WE MUST: | | | | | | | | | | | | | | | | | | | | | | | | |
| discontinue your | | | | |  | | | | | | | grant effective for the month of | | | | | | | |  | | | | |
| reduce your | | | |  | | | | | | | grant to |  | | | | effective for the month of | | | | | | |  | |
| The reason for this decision is that | | | | | | | | | | | | | | | | | | | | | | | | |
| discontinue MO HealthNet for | | | | | | | | |  | | | | | | | | | | | | | | | |
| The last day of MO HealthNet coverage is | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | (MONTH) | | | | | | (DAY) | | | | | (YEAR) | | | |  | | |
| The reason for this decision is that | | | | | | | | | | | | | | | | | | | | | | | | |
| other: | | Your Children’s Health Insurance Program premium is increasing effective July 1, 2014 due to our annual | | | | | | | | | | | | | | | | | | | | | | |
|  | | adjustment. You will be informed by the MO HealthNet Division of your new premium amount. An IM-4PRM | | | | | | | | | | | | | | | | | | | | | | |
|  | | Premium Notice is enclosed for your review. If you have any questions please contact MO HealthNet | | | | | | | | | | | | | | | | | | | | | | |
|  | | Participant Services at 1-800-292-2161 or the FSD Info Center at 855-FSD-INFO(855-373-4636). | | | | | | | | | | | | | | | | | | | | | | |
|  | | The reason for this decision is found in RSMO 208.640.1. | | | | | | | | | | | | | | | | | | | | | | |
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| If you seek medical coverage under another health insurance plan, such as a group plan offered by your employer, you may need a Certificate of Creditable Coverage showing when you were covered by MO HealthNet. The certificate may help prove you have met part or all of an exclusionary period for pre-existing medical conditions. You may request a certificate within 24 months of losing MO HealthNet benefits. You may request a certificate by calling the MO HealthNet Division, Recipient Services at 1-800-392-2161. | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | |  |
| If you agree with this decision, you do not have to request a hearing. If you do not request a hearing, we will discontinue or reduce your assistance following the date indicated above. If you believe this decision is wrong or if you have | | | | | | | | | | | | | | | | | | | | | | | | |
| information that you believe will prove you need to continue to receive your present amount of assistance, you have | | | | | | | | | | | | | | | | | | | | | | | | |
| until | | | | | |  | | | | | | | | | | | | | to request a hearing. | | | | | |
|  | | | | | | (DAY OF WEEK) (MONTH) (DAY) (YEAR) | | | | | | | | | | | | |  | | | | | |
| If you wish to have a hearing, you may request it by mail, by telephone, or in person. To request a hearing | | | | | | | | | | | | | | | | | | | | | | | | |
| by telephone, call    -   - | | | | | | | To request a hearing by mail, you may fill out and return the information on page 2. | | | | | | | | | | | | | | | | | |
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| If you request a hearing by the date above, your benefits may continue pending the results of the hearing. If the hearing decision shows that the plan to reduce your benefits or close your case was correct, your household will be responsible for repaying the amount of benefits you were not entitled to receive while your hearing was pending. If you elect to discontinue receiving benefits while your hearing is pending and the hearing decision is ruled in your favor, lost benefits will be restored to you. | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 you may be represented by your own attorney or by other persons who know your situation. If you do not have an attorney, or cannot afford one, and live in an area served by a legal aid or legal services office, you may be eligible for this service. | | | | | | | | | | | | | | | | | | | | | | | | |
| For the possibility of free legal services call: | | | | | | | | | | -   - | | | | . You have the right to present witnesses | | | | | | | | | | |
| on your own behalf and to question witnesses who appear at the request of the Family Support Division. | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNATURE | | | | | | | | TITLE | | | | | | | | | TELEPHONE     -   - | | | | | | | |
| ENCLOSURE: INFORMATION LEAFLET(S) NO. IM-4 | | | | | | | | | | | | | | | | | | | | | | | | |
| MO 886-0747 (01-2014) | | | | | | | | | | | | IM-80 (01-2014) | | | | | | | | | | | | |

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| **IF YOU WANT A FAIR HEARING, FILL**  **OUT THIS FORM AND MAIL IT TO:** | |  |  | | | |
| NAME OF PERSON REQUESTING HEARING | | | ADDRESS | | | |
| TELEPHONE NUMBER WHERE YOU CAN BE REACHED | | | YOUR SIGNATURE | | | TODAY’S DATE |
| USE THIS SPACE TO TELL US WHY YOU WANT A FAIR HEARING | | | | | | |
| **FOR OFFICE USE ONLY** | | | | | | |
| CASE NO. | CASEWORKER | | | LOAD NO. | DATE NOTICE SENT  July 1, 2014 | DATE REQUEST RECEIVED |
| MO 886-0747 (01-2014) | | | IM-80 (01-2014) | | | |