



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF FAMILY SERVICES
APPROVAL NOTICE

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	NOTE: Case number(s) listed above is not a Medicaid number. See back side for Medicaid number.	

This is to advise you the following persons are approved for the stated type of assistance:

You have been approved as a Qualified Medicare Beneficiary effective _____.
 You may expect payment of your Medicare premiums to begin within 60 to 90 days from the date of this letter.

Persons listed below were determined not eligible for the stated type of assistance:

because _____

Based on information you helped provide, our investigation of your income and expenses shows that:

- your monthly check will be \$ _____. This is based on income before taxes of \$ _____ per _____.
- you have \$ _____ of your own income which could be applied toward your medical expenses. Since your medical expenses have exceeded this amount, you now qualify for medical assistance coverage through _____. If you wish medical coverage beyond this date, you must reapply after _____ and if possible before _____ 19 ____.
- the assistance grant (from box 1) is determined without considering child support or alimony as direct income to the household. Therefore, as of _____ it is required that all child support and alimony received by you must be sent to the Support Enforcement Agency located at _____.
- other: _____

If you agree with the above decision, you do not have to request a hearing.

If you disagree with this decision you have the right to request a hearing within 90 days from the date of this letter.

If you request a hearing you may present your information yourself or be represented by your own attorney or by other persons who have knowledge of your situation. You have the right to present witnesses in your own behalf and to question witnesses who appear at the request of the Division of Family Services. For possibility of free legal services, call: _____.

All assistance checks and/or medicaid card, are mailed directly to you from the office of the Division of Family Services in Jefferson City. You may expect to receive your first payment approximately two weeks from the date of this letter.

Read the enclosed leaflet for important information about your assistance. Keep it for future reference.

To be sure that your check, and/or medicaid card, is delivered on time each month it is very important that you inform us immediately when you move or change your address.

If your situation changes it is your responsibility under the law to report these changes at once to the local county 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
IMPORTANT: THE BACK OF THIS FORM MAY CONTAIN VERIFICATION OF YOUR MEDICAL COVERAGE	