**SAMPLE LETTER**

**FINDING APPLICANT INELIGIBLE FOR**

**A DD WAIVER**

Date

**VIA CERTIFIED MAIL**

**RETURN RECEIPT REQUESTED**

**AND REGULAR U.S. MAIL**

Name

Street Address

City, State, ZIP

Re:      ’s Request to Participate in the DD      ] Waiver

Dear      :

 Name has submitted a request to participate in the DD  Waiver. After an evaluation of whether service provision through this waiver is appropriate for Name, I have determined that he/she is ineligible for the  Waiver on the basis that name INSERT REASON(S) FROM WAIVER INELIG REASON PAGE

 You have the right to appeal through the Department of Mental Health and Department of Social Services, MO Health Net Division at 1-800-392-2161. While not required to do so, you are encouraged to begin with the Department of Mental Health’s appeal process. You may, however, appeal to the MO HealthNet Division, before, during, or after exhausting the Department of Mental Health process. However, once an individual begins the appeal process with the Department of Social Services, all appeal rights with the Department of Mental Health end. If you wish to appeal my decision, you may contact Contact Name at Contact Phone & Address within       days of receiving this letter.

Sincerely,

Name of RD

Director,  Regional Office