**SAMPLE LETTER**

**FINDING PARTICIPANT IN A DD WAIVER INELIGIBLE FOR**

**A NEW OR INCREASED SERVICE**

Date

**VIA CERTIFIED MAIL**

**RETURN RECEIPT REQUESTED**

**AND REGULAR U.S. MAIL**

Name/Guardian

Street Address

City, State, ZIP

Re: Name’s request for [list particular service request here]

Dear Name/Guardian:

 Name is a participant in the DD  Waiver. Name has requested Insert Requested Service(s) through the Waiver. After a review of this request, as well as Name’s individual support plan and List Support Documents or processes reviewed , I am approving the following services:

XXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXX

The following services have been approved with modification:

YYYYYYYYYYYYYYYYY

YYYYYYYYYYYYYYYYY

This decision was reached because of the following reason(s):

I am denying the request for ZZZZZ This decision was reached because of the following reason(s):

 You have the right to appeal my decision 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’s 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 Name at Contact Address & Phone within       days of receiving this letter.

Sincerely,

Name

Director,  Regional Office