SAMPLE LETTER
TERMINATING PARTICIPATION IN A DD WAIVER

Date

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED
AND REGULAR U.S. MAIL

Name/Guardian Name
Street Address
City, State, ZIP

Re: Name's request for Service

Dear Name/Guardian:

Name has been a participant in the DD Autism Waiver. This letter is to notify you that 's participation in this Waiver will be terminated on date for the following reason:

Insert Reason(s) from Waiver Termination Reasons sheet

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 Contact Name at Contact Address & Phone within days of receiving this letter.

Sincerely,

RD Name
Director, Albany Regional Office

Technical Reasons for Termination from a Waiver
Insert all that apply from the following list into the Waiver Termination Letter (#4).
Do not include any explanatory notes in red into the letter.
Please replace "you" with name of individual if the letter is directed to the guardian.

- You have moved out of the State of Missouri. Missouri residence is required for waiver participation.

- You are no longer eligible for MO HealthNet. MO HealthNet eligibility is required for waiver participation. *(Note: this would also apply if individual is eligible under Spend down and fails to meet pend down for at least 3 consecutive months).*

- After receipt of additional clinical information, it appears that NAME does not have an intellectual disability or a related condition, as defined in 42 C.F.R. 435.1010, in that he or she does not have a chronic disability attributable to (1) cerebral palsy or epilepsy or (2) any other condition, other than mental illness, found to be closely related to intellectual disability that results in impairment of general intellectual functioning or adaptive behavior similar to that of those with intellectual disability and requires treatment or services similar to those required for these persons

- You do not have a need for a continuous active treatment program, including aggressive consistent implementation of a program of training, treatment, health services or related services that are directed toward the acquisition of or prevention of loss of current optimal functioning.

- There is no reasonable indication that the only alternative services that meet your needs, if waiver services are not available, are services through an ICF/DD.

- You do not require the provision of at least one waiver service, as documented in the service plan.

- You do not require the provision of waiver services at least monthly. You have received no waiver services for Insert # of Months Here.

- You have moved to a county not covered under the Partnership for Hope Waiver.

- You have requested that your waiver case be closed.

- You have asked that your services be funded through another waiver. Since an individual can be funded through only one waiver at a time, your participation in XXX waiver has been terminated, and your participation in YYYYY waiver has been initiated.