MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

APPLICATION FOR STATE HEARING FOR HOME AND COMMUNITY BASED SERVICES

APPLICANT NAME	DCN	COUNTY

ADDRESS, CITY, STATE, ZIP CODE	PHONE/EXTENSION

NAME

Hereby makes application for a hearing as provided by state law.

PLAINLY STATE THE REASON FOR THE HEARING REQUEST

AUTHORIZED REPRESENTATIVE

You do not need to complete and sign this section in order to request a hearing

NAME	PHONE/EXTENSION

ADDRESS, CITY, STATE, ZIP CODE

If you are currently receiving services and request a hearing within ten (10) calendar days of the date this notice is mailed, your services will continue unchanged while your hearing is pending, unless you tell us otherwise.

If the decision of the division is determined to have been correct and you lose the hearing, the state has the ability to hold you, or your estate, responsible for repaying the cost of services you received while your hearing was pending.

☐ Yes – I wish to continue receiving services at the current level.

☐ No – I do not wish to continue receiving services at the current level.

APPLICANT'S SIGNATURE, WHEN AVAILABLE	DATE

TO BE COMPLETED BY DIVISION OF SENIOR AND DISABILITY SERVICES

APPLICANT IS APPEALING (CHECK ONE)	DATE HEARING REQUESTED
☐ Denial ☐ Discontinuance ☐ Reduction	

REASON FOR PLANNED ACTION OR DECISION	SERVICE(S) BEING ADVERSELY AFFECTED

DSDS STAFF	PHONE NUMBER/EXTENSION

ADDRESS, CITY, STATE, ZIP CODE

SUPERVISOR'S SIGNATURE

FOR DIVISION OF LEGAL SERVICES USE ONLY

DATE RECEIVED BY DLS	ASSIGNED DLS HEARING OFFICER