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

COVER LETTER FOR HEARING REQUEST

DATE

DLS HEARINGS OFFICE ADDRESS

PARTICIPANT NAME	PARTICIPANT DCN
PARTICIPANT ADDRESS	PARTICIPANT LAST KNOWN PHONE NUMBER

The participant named above has requested a hearing regarding the Adverse Action listed as Exhibit 1. All exhibits have been provided to the participant and/or their authorized representative.

List all documents below and mark each with the appropriate exhibit designation.
Additional documents may be listed on a separate page.

Exhibit 1	Adverse Action Notice	Page(s)
Exhibit 2	Application for State Hearing	Page(s)
Exhibit 3	HCBS Assessment Attestation	Page(s)
Exhibit 4	Case Notes	Page(s)
		Page(s)
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The primary witness on behalf of DHSS, Division of Senior and Disability Services is indicated below. Please advise if additional information is needed for this hearing.

DSDS STAFF SIGNATURE	DSDS STAFF NAME (PRINTED)	PHONE NUMBER

DSDS OFFICE ADDRESS, CITY, STATE, ZIP CODE