

# Missouri Family Support Division

## **Spend Down** Unit

# Welcome

## Presenting from Missouri FSD **Spend Down** Unit:

- \* Roxie Sponsler, Manager
- \* Bridget Robertson, Supervisor
- \* Bryce Williamson, Supervisor
- \* Leanna McDaniel, Supervisor
- \* Lori Vandiver, Supervisor

# What Makes a case a **Spend Down**?

- \* Eligibility guidelines are the same as for regular MO HealthNet cases.
- \* They become **spend down** if their income is over the maximum allowable amount which is:
  - \* \$842.00 for a single person
  - \* & \$1135.00 for a couple at this time.
    - \* These amounts are adjusted each year in April

# What Makes a case a **Spend Down**?

- \* The budget counts all gross income of the applicant & spouse (if living together)
  - \* A deduction of \$20.00 is taken off the total gross amount
  - \* Any health insurance premiums (including Medicare) are also deducted from the gross income
  - \* There are additional deductions for Earned Income
- \* After deductions, if the remaining amount is over the maximum, the dollar amount over is the **spend down** amount that must be met each month.

# Example **Spend Down** Budget:

- \* 1 Person household-Income is Social Security of \$1291.00 less \$104.90 Medicare premium.

\$1,291.00 Gross income

\$ -20.00 Personal Income Exemption

\$1,271.00 Adjusted Gross Income

\$ -104.90 Medicare Premium

**\$1,166.10 Final Adjusted Gross Income**

\$ -842.00 MHABD Income Maximum

\$ **324.10** Income over maximum

- \* **Spend Down** is \$324.00 monthly

# Ways to meet the **Spend Down** amount

- \* The client is responsible for the **spend down** amount each month
- \* It is similar to a deductible, as soon as it is met, their MO HealthNet coverage will go into effect on that date and continue through the last day of the month

# Ways to meet the **Spend Down** amount

- \* Ways to meet **spend down** are:
  - \* Pay the **spend down** to the Premium Payment Unit by sending a check or money order to:
    - \* **MO HealthNet Division**  
**Premium Payment (**Spend Down**)**  
**P O Box 808001**  
**Kansas City, MO 64180-8001**
  - \* Or complete an auto withdrawal form to have it taken from a checking or savings account monthly.
    - \* When meeting **spend down** with this option, coverage begins the first day of the month.

# Ways to meet the **Spend Down** amount (cont.)

- \* Clients can send in bills or receipts they have received for medically necessary services to the **Spend Down** Unit
  - \* Coverage will begin the date the acceptable expenses meet the **spend down** amount
- \* MO HealthNet **Spend Down** Provider form completed by the provider and submitted to the **Spend Down** Unit.

# Verification of Expenses

- \* If meeting **Spend Down** with bills or receipts the document must show the following:
  - \* Date of Service
  - \* Type of Service Provided
  - \* Charge for Service Provided
  - \* Amount of third party liability (amount paid and adjusted/discounted by insurance and/or provider)
  - \* Amount client is responsible to pay
- \* Itemized statements or account summaries are not acceptable.

# Verification of Expenses (Cont.)

- \* Bills are not typically received for prescriptions.
- \* Acceptable documentation is:
  - \* Tear strip showing the name of medication and fill date along with the corresponding cash register receipt, or
  - \* Patient Profile printout from pharmacy along with the cash register receipt, or
  - \* Patient Profile printout from pharmacy with the statement “attested to by” on it and signed and dated by pharmacist.
    - \* The pharmacist needs to understand they are attesting to the fact that the amount listed on printout is what the client paid and the medication that was received.

# Spend Down Provider Form Tips

- \* **Date of Service:** Each row going across must be for one date of service, cannot combine multiple dates of service on one line.
- \* **Service Description:** This is a description of the medically necessary service provided to the client.
- \* **Procedure Code:** This is the procedure code used to submit claims to MO HealthNet Division.
- \* **Name of Liable Third Party:** This is any insurance other than MO HealthNet.

# Provider Form Tips (Cont.)

- \* **Total Amount of Charge:** This is the total daily charge incurred by the client before any payment, discounts or deductions.
- \* **Amount of Expense Billable to Third Party:** This is the amount the third party will or has paid.
  - \* Enter \$.00 if no Third Party.
  - \* If payment hasn't been received yet and you know what the amount will be, you can initial and attest to the information as being a good faith estimate as to what the client will owe and be billed (Initial and attest in paragraph below columns on form).

# Provider Form Tips (Cont.)

- \* **Write off or Other Discounts:** This is the amount of incurred expenses written off or any discounts given that will not be billed to the client. Enter zero if no discounts.
- \* **Total Daily Expense Patient is Responsible to Pay:** This is the amount of the expenses that will be billed to the client and is their responsibility to pay. This amount should equal the Total Charge column minus Amount Billable to Third Party minus the Write Off or Discounts.
- \* **Total Amount Billable to State Only Funds (DMH, DHSS contracts):** This field is only for expenses billable to Department of Mental Health or Department of Health and Senior Services.
- \* **If you are sending expense documents to the Spend Down Unit, please send each person individually and not as multiple clients/patients in one fax.**



MO HealthNet Spend Down Provider Form

Provider Instructions: Please assist your patient by completing the following information. By completing this form, you are verifying medical expenses have been incurred and are owed by your patient. The "Total Daily Expense Patient is Responsible to Pay" column should reflect the patient's incurred expenses for which they are personally responsible to pay.

ATTENTION: All fields on this document are required to be completed, unless an attachment(s) verifying the required information for the incomplete field is provided.

Patient Name (Print): Any One MO HealthNet Number: 12345678

Provider Name: Dialysis Facility / Company

Check One: Doctor Pharmacy Hospital: In-patient Out-patient Other

Table with 9 columns: Date of Service, Service Description, Procedure Code, Name of Liable Third Party(s), Total Amount of Charge, Amount of Expense Billable to Third Party, Write off or Other Discount (i.e. Indigent Waiver), Total Daily Expense Patient is Responsible to Pay, Total Amount Billable to State Only Funds (i.e. DMH, DHSS contracts). Includes an example row and several rows of dialysis data.

BY COMPLETING AND SIGNING THIS DOCUMENT, YOU ARE ATTESTING TO THE ACCURACY OF THE INFORMATION PROVIDED AND THAT THE PATIENT WILL BE BILLED FOR THE AMOUNT DUE. PLEASE INITIAL HERE IF THIS FORM IS COMPLETED BASED ON A GOOD FAITH ESTIMATE OF THE EXPENSES OWED/BILLABLE TO PATIENT:

THE FOLLOWING INFORMATION IS REQUIRED TO BE COMPLETED BY THE PROVIDER:

Name of Provider or Authorized Employee Completing Form (Please print): Mary Jo Merry

Title: Patient Account Representative Date: 1/14/2016

Address: 1234 North, Beautiful MO 60000 Phone: xxx-xxx-xxxx

Signature of person completing form: Mary Jo Merry

This form is not considered acceptable verification of allowable spend down expenses without completion of the required fields and attestation. This form does not replace the responsibility of the provider to bill the patient or submit a claim to MO HealthNet Division.

PROVIDER FORM

EXAMPLE

(MO 886-4501)

A blank MO 886-4501 can be found in the Forms Manual (on the intranet) under: MO HealthNet Spend Down Provider Form



# MO HealthNet Spend Down Provider Form

PROVIDER  
FORM  
EXAMPLE  
(MO 886-4501)

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Patient Name (Print): Any One MO HealthNet Number: 12345678

Provider Name: Dialysis Facility / Company

Check One:  Doctor  Pharmacy Hospital:  In-patient  Out-patient  Other

Date of Service	Service Description	Procedure Code	Name of Liable Third Party(s)	Total Amount of Charge	Amount of Expense Billable to Third Party	Write off or Other Discount ( i.e. Indigent Waiver)	Total Daily Expense Patient is Responsible to Pay	Total Amount Billable to State Only Funds (i.e. DMH, DHSS contracts)
EXAMPLE: 08/01/2012	CPR Medication Services	90862	DMH	\$80.00	\$80.00	\$0.00	\$0.00	\$80.00
4/15/2015	Dialysis	90999	Medicare	\$4,386.80	\$184.53	\$4,155.07	\$47.20	\$0.00
4/17/2015	Dialysis	90999	Medicare	\$4,386.80	\$184.53	\$4,155.07	\$47.20	\$0.00
4/20/2015	Dialysis	90999	Medicare	\$4,386.80	\$184.53	\$4,155.07	\$47.20	\$0.00
4/22/2015	Dialysis	90999	Medicare	\$4,386.80	\$184.53	\$4,155.07	\$47.20	\$0.00
4/24/2015	Dialysis	90999	Medicare	\$4,386.80	\$184.53	\$4,155.07	\$47.20	\$0.00
4/27/2015	Dialysis	90999	Medicare	\$4,386.80	\$184.53	\$4,155.07	\$47.20	\$0.00

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Patient Name (Print): Any One MO HealthNet Number: 12345678

Provider Name: Dialysis Facility / Company

Check One:  Doctor  Pharmacy  Hospital:  In-patient  Other  
 Out-patient

Date of Service	Service Description	Procedure Code	Name of Liable Third Party(s)	Total Amount of Charge	Amount of Expense Billable to Third Party	Write off or Other Discount ( i.e. Indigent Waiver)	Total Daily Expense Patient is Responsible to Pay	Total Amount Billable to State Only Funds (i.e. DMH, DHSS contracts)
<i>EXAMPLE:</i> 08/01/2012	<i>CPR Medication Services</i>	90862	DMH	\$80.00	\$80.00	\$0.00	\$0.00	\$80.00
4/29/2015	Dialysis	90999	Medicare	\$4,386.80	\$184.53	\$4,155.07	\$47.20	\$0.00

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# PROVIDER FORM EXAMPLE (MO 886-4501)

# ELECTRONIC REMITTANCE ADVICE

Electronic Reproduction

Medicare Part A  
CAHABA GBA, LLC (GA)  
8115 KNUE ROAD  
INDIANAPOLIS IN 46250

CHECK DATE: 06/30/2015

CHECK/EFT: EFT1425986

Statement Period Start 04/01/2015  
Account

Statement Period End: 04/29/2015

Provider:

ICN:

Status: Processed as Primary

PreProv	ServDate	NOS	REV	Proc/Mod	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary
					74.06	74.06			74.06	0.00	97
2000010365	04/01/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2010010365	04/01/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2020010365	04/03/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2030010365	04/05/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2040010365	04/06/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2050010365	04/08/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2060010365	04/10/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2070010365	04/13/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2080010365	04/13/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2090010365	04/15/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2100010365	04/17/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2010010365	04/17/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2020010365	04/20/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2030010365	04/22/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2040010365	04/22/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2050010365	04/24/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2060010365	04/27/2015	1	0270	HC:A4657	74.06	74.06			74.06	0.00	97
2070010365	04/28/2015	1	0270	HC:A4657	91.15	91.15			91.15	0.00	97
2080010365	04/20/2015	1	0304	HC:00307-CB	1,004.92	1,004.92			1,004.92	0.00	97
2090010365	04/20/2015	1	0304	HC:80059-CB	295.77	295.77			295.77	0.00	97
2100010365	04/20/2015	1	0304	HC:82728-CB	140.60	140.60			140.60	0.00	97
2110010365	04/20/2015	1	0304	HC:83540-CB	145.45	145.45			145.45	0.00	97
2120010365	04/20/2015	1	0304	HC:83735-CB	896.94	896.94			896.94	0.00	97
2130010365	04/20/2015	1	0304	HC:83670-CB	112.33	112.33			112.33	0.00	97
2140010365	04/20/2015	1	0304	HC:84075-CB	79.64	79.64			79.64	0.00	97
2150010365	04/20/2015	1	0304	HC:84135-CB	115.01	115.01			115.01	0.00	97
2160010365	04/20/2015	1	0304	HC:84460-CB	277.26	277.26			277.26	0.00	97
2170010365	04/20/2015	1	0304	HC:84520-CB-91	64.33	64.33			64.33	0.00	97
2180010365	04/06/2015	1	0304	HC:85018-CB	51.37	51.37			51.37	0.00	97
2190010365	04/13/2015	1	0304	HC:85018-CB	51.37	51.37			51.37	0.00	97
2200010365	04/27/2015	1	0304	HC:85018-CB	87.04	87.04			87.04	0.00	97
2210010365	04/20/2015	1	0304	HC:85045-CB	224.14	224.14			224.14	0.00	97
2220010365	04/20/2015	1	0304	HC:87340-CB	1,155.20	1,155.20			1,155.20	0.00	97
2230010365	04/03/2015	38	0634	HC:Q4081-JA	1,155.20	1,155.20			1,155.20	0.00	97
2240010365	04/10/2015	38	0634	HC:Q4081-JA	1,155.20	1,155.20			1,155.20	0.00	97
2250010365	04/17/2015	38	0634	HC:Q4081-JA	592.20	592.20			592.20	0.00	97
2260010365	04/24/2015	38	0634	HC:Q4081-JA	592.20	592.20			592.20	0.00	97
2270010365	04/01/2015	6	0636	HC:J1270	592.20	592.20			592.20	0.00	97
2280010365	04/03/2015	6	0636	HC:J1270	592.20	592.20			592.20	0.00	97
2290010365	04/06/2015	6	0636	HC:J1270	592.20	592.20			592.20	0.00	97
2300010365	04/08/2015	6	0636	HC:J1270	592.20	592.20			592.20	0.00	97
2310010365	04/10/2015	6	0636	HC:J1270	592.20	592.20			592.20	0.00	97
2320010365	04/13/2015	6	0636	HC:J1270	592.20	592.20			592.20	0.00	97
2330010365	04/17/2015	6	0636	HC:J1270	592.20	592.20			592.20	0.00	97
2340010365	04/20/2015	6	0636	HC:J1270	592.20	592.20			592.20	0.00	97
2350010365	04/22/2015	6	0636	HC:J1270	394.80	394.80			394.80	0.00	97
2360010365	04/24/2015	4	0636	HC:J1270	394.80	394.80			394.80	0.00	97
2370010365	04/27/2015	4	0636	HC:J1270	394.80	394.80			394.80	0.00	97
2380010365	04/29/2015	4	0636	HC:J1270	872.40	872.40			872.40	0.00	97
2390010365	04/06/2015	50	0636	HC:J1756	872.40	872.40			872.40	0.00	97
2400010365	04/13/2015	50	0636	HC:J1756	872.40	872.40			872.40	0.00	97
2410010365	04/20/2015	50	0636	HC:J1756	1,751.60	1,751.60			1,751.60	0.00	97
2420010365	04/22/2015	1	0636	HC:90740	1,834.57	1,834.57			1,834.57	117.03	45
											253

10:

2000010365	04/22/2015	1	0771	HC G0010	120.71	120.71		96.66	24.05	CO	45	96.1
2000010365	04/01/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	118	4,155.07
2000010365	04/03/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	45	4,155.07
2000010365	04/06/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	118	4,155.07
2000010365	04/08/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	45	4,155.07
2000010365	04/10/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	118	4,155.07
2000010365	04/13/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	45	4,155.07
2000010365	04/15/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	118	4,155.07
2000010365	04/17/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	45	4,155.07
2000010365	04/20/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	118	4,155.07
2000010365	04/22/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	45	4,155.07
2000010365	04/24/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	118	4,155.07
2000010365	04/27/2015	1	0821	HC 90999	4,386.80	236.00	47.20	4,155.07	184.53	CO	45	4,155.07
2000010365	04/29/2015	1	0821	HC 90999 G4 V7	4,386.80	236.00	47.20	4,155.07	184.53	CO	118	4,155.07
<b>REMITTANCE SUMMARY</b>					<b>75,489.06</b>	<b>24,413.65</b>	<b>00</b>	<b>613.60</b>	<b>75,335.49</b>	<b>2,539.97</b>		

TOTALS

Denied/Non-Covered: 115.01			
CO	97	19,473.34	[Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated]
*CO	119	115.01	[Benefit maximum for this time period or occurrence has been reached]
CO	45	55,688.75	[Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)]
CO	253	51.89	[Sequestration - reduction in federal spending]
CO	118	6.50	[Charges reduced for ESRD network support]
PR	2	613.60	[Coinsurance Amount]
AMT	I	3.99	[INTEREST]
AMT	AU	24,413.65	[Coverage Amount]
AMT	DY	1.00	[Per Day Limit]
HE	M86		[Service denied because payment already made for same/similar procedure within set time frame]

\* Denotes denied or non-covered charges  
 MA01: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g. hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or

# Carryover Policy

- \* Carryover can be a very confusing policy
- \* These are some key points to remember:
  - \* Client may use expenses that were paid or incurred.
  - \* Being aware of the allowable time frame is essential.
  - \* The expenses must have been incurred within the three months prior to the current month and can be requested to be applied to the current month and/or any of the next three months.
    - \* For example, if we receive a request to carryover expenses in January, the expenses would need to have been incurred in October, November or December. We can apply the expense to January (current month), February, March or April.

# Carryover (cont.)

- \* It is usually better for the client if these expenses are not MO HealthNet eligible such as dental, optical or chiropractic
  - \* IF the charges can be covered by MO HealthNet, the client needs to be aware that if they are carried over to another month they are forfeiting coverage for that month
  - \* They cannot meet their **spend down** that month or the bill would be paid and there would be nothing to carry over
- \* If it is a bill that MO HealthNet covers and client wants it applied to the month of service, the expense will be paid by MO HealthNet leaving nothing to carry over
- \* Expenses cannot have been used for Out of Pocket or applied towards meeting their **spend down** in the month it was incurred.

# Carryover (Cont.)

- \* Once expenses have been designated to a specific month, the client cannot later go back and designate them to a different month
  - \* The designation must be in writing, signed and dated by the client and/or spouse.
  - \* When the carryover form is completed, it must be signed each time carryover is requested.
  - \* These forms should not be photocopied with client's signature and resubmitted each month.

# Carryover (Cont.)

- \* Client must have been an active **Spend Down** participant and not receiving SLMB2 in the month the expense was incurred.
- \* A provider form cannot be used for carryover.
  - \* We must receive a bill or invoice.

# Contacting the Spend Down Unit

- \* All expenses should be sent to the Spend Down Unit either by fax or email.
- \* If emailing, the expenses must be attached to the email as a pdf document. Numbers are listed below:
  - \* Faxes:
    - \* 855-600-3754 (Toll Free Fax for Spend Down ONLY)
  - \* Email
    - \* [sesd@ip.sp.mo.gov](mailto:sesd@ip.sp.mo.gov)

# Contacting the **Spend Down** Unit (cont.)

- \* Any questions or concerns can be directed to our **Spend Down** Unit by phone or email as follows:
  - \* **Phone: (Toll Free) 855-600-4412**
    - \* **Manager and Supervisor Extensions**
      - \* Roxie Sponsler, Manager 250
      - \* Bridget Robertson, Supervisor 227
      - \* Bryce Williamson, Supervisor 229
      - \* Leanna McDaniel Supervisor 270
      - \* Lori Vandiver, Supervisor 246
  - \* **Email:**
    - \* [Spenddown.unit@dss.mo.gov](mailto:Spenddown.unit@dss.mo.gov)

Thank you!