

CMHC Healthcare Home  
Client Opt-Out Confirmation Letter

<Date>

Name

Street Address

City, State Zip Code

RE:

DCN:

Dear <Name>:

Your request for opting out of receiving Healthcare Home services from <CMHC provider> has been approved. Participation in this program is voluntary. Healthcare Home services would be covered under your current MO HealthNet plan at no additional charge to you.

Declining Healthcare Home services will not affect other MO HealthNet covered services you currently receive from <CMHC provider> and other providers.

If you wish to receive Healthcare Home services in the future, please contact your Community Mental Health Center for assistance in enrolling for these enhanced services.

Sincerely,