MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

WITHDRAWAL OF REQUEST FOR HEARING

FROM	COUNTY DIRECTOR	TELEPHONE NUMBER	DATE
	COUNTY OFFICE ADDRESS (STREET, CITY, STATE, ZIP CODE)		

TO	NAME		
	ADDRESS (STREET)		
	CITY	STATE	ZIP CODE
	CASE NAME		DCN

My continued eligibility for _____ has been discussed with me by a representative of _____ County staff.

☐ I understand that the proposed action will be taken to:

- ☐ reduce benefits to $ _____ .
- ☐ decrease food stamp Issuance to $ _____ .
- ☐ discontinue benefits.
- ☐ reject an application.
- ☐ other: _____ .

☐ I understand that the county office has withdrawn their proposed action to:

- ☐ reduce benefits to $ _____ .
- ☐ decrease food stamp Issuance to $ _____ .
- ☐ discontinue benefits.
- ☐ reject an application.
- ☐ other: _____ .

On the basis of the above information, I approve the Division of Family Services decision to withdraw their proposed action dated _____ .

☐ I have had a conference with my caseworker.

☐ I agree with the decision, previously made by the Agency.

By signing this form I am WITHDRAWING my request for a hearing on the above issue.

I understand that my eligibility for assistance will:

- ☐ continue at the current rate.
- ☐ result in a reduced benefit.
- ☐ be discontinued or rejected.

My eligibility for assistance may be redetermined at a future date, if I decide to reapply. At that time if a change in eligibility is proposed, I will have a right to a hearing on that action.

SIGNATURE	DATE

I HEREBY CERTIFY THAT I HAVE EXPLAINED THE ELIGIBILITY FACTORS AND AGENCY WITHDRAWAL OF PROPOSED ACTION DATED _____ .

SIGNATURE	TITLE	DATE