MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
REQUEST FOR REDUCTION OF CLAIM

Head of Household for Claim:		
DCN:	Original Amount of Claim:	Date Claim Established:

Please complete the following information regarding your financial situation. Include information for all persons who live with you. If they do not owe this claim, their income and expenses will not be counted.

How many people live in your household:	Total cash, bank accounts and CD's:

Does anyone who lives with you receive Supplemental Nutrition Assistance Program (SNAP) benefits? Yes ☐ No ☐

- If yes, who:

Monthly Household Income: (Example: Social Security, SSI, Wages, Unemployment, Child Support, etc.)

Name	Where is Income From:	Monthly Amount of Income

Monthly Expenses: (Example: rent, utilities, car payments, medical expenses, child support, min. credit card pmt.)

Type of Expense	Who Pays This Expense	Monthly Amount of

Describe any other reasons that would cause a financial, physical or mental hardship for you to repay this claim. You may use the back of this form for additional comments:

Signature of person Requesting Claim Reduction:	Date:

Return completed form to: SNAP Program and Policy Unit
P.O. Box 2320
Jefferson City, MO 65102

Office Use Only

Original amount of Claim:	Amount Compromised:	Balance of Claim :	CARS-2 Submitted:
Approved By:			Date: