MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
WAIVER OF 10-DAY ADVANCE NOTICE

Missouri Department of Social Services

Name:	DCN:	Date:

Family Support Division (FSD) participants can choose to voluntarily end benefits or reduce their benefits. With this written notice, an action that requires FSD to provide 10 day advance notice of adverse action to end or reduce benefits will be effective immediately.

My eligibility for _____ has changed because:

_____

I understand that because of this change, my benefits are changing.

☐ My benefits will end on: _____

☐ My benefits will decrease or change to: _____

on: _____

for the following participants: _____

☐ Other changes: _____

By signing this form, I agree that the eligibility factors have been explained to me and I understand my benefits will end or be changed as shown above.

- I understand that I am giving up my rights to a ten (10) day waiting period.
- I understand that by giving up this waiting period, my benefits will not continue if or when I request a fair hearing.
- I understand that I cannot request a hearing until the change is made.
- I understand that I can request a hearing within ninety (90) days of the date of the notice I receive showing that a change has been made.

If submitting electronically – I have agreed to submit this form by electronic means. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. ☐ I agree

Participant's Signature	Date

FSD Staff - ONLY complete this section if you discuss this action with the participant

I have explained to the participant named above: the change in benefits, the contents of this form, and their rights to a fair hearing.

FSD Staff Name	Job Title	Date

SAVE PRINT RESET