

MISSOURI DEPARTMENT OF SOCIAL SERVICES

FAMILY SUPPORT DIVISION

**Request to Withdraw or Close**

 Date\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Name | Social Security Number | Case Number  |
| Physical Address |
| Mailing Address  |

|  |
| --- |
| I wish to voluntarily withdraw or close my application/case for the program(s) checked below: |
| * Food Stamps (SNAP)
 | * Child Care (CC)
 | * Temporary Assistance for Needy Families (TANF)
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| * Blind Pension (BP)
 | * Supplemental Aid to the Blind (SAB)
 | * Breast or Cervical Cancer Treatment (BCCT)
 |
| * Qualified Medicare Beneficiary (QMB)
 | * Specified Low Income Beneficiary (SLMB)
 | * MO HealthNet for Kids (MHK)
 |
| * MO HealthNet for Families (MHF)
 | * MO HealthNet for Pregnant Women (MPW)
 | * MO HealthNet for Uninsured Women (UWHS)
 |
| * MO HealthNet for the Age, Blind, or Disabled (MHABD)
 | * Show Me Healthy Babies (SMHB)
 |  |
| I wish to remove\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ from my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_case/application. (name) (TYPE of Assistance) |
| Other specific instructions from the participant. (Example: Close SLMB; leave MHABD open.) |
| B By signing this form, I am confirming that the eligibility factors have been explained to me and I understand my benefits will end or change as stated above. I am waiving the 10-day period in which I can both request a hearing and keep my benefits open until the hearing decision is done. I can still request a hearing on this action, but if my benefits change immediately, they cannot be restored unless the hearing decision awards them to me or my circumstances change. However, I can request a hearing on this decision within 90 days of the notice I receive indicating this change has been made. |
| Participant Signature | Date |
| **I have explained the eligibility factors, this form, and rights to a fair hearing to the above participant.** |
| Eligibility Team Member Signature | Date |