Missouri Department of Social Services

HEARING REQUEST

For use by participants and authorized representatives ONLY

Section A - Participant Information (required fields are in **bold**)

First Name	Middle Initial	**Last Name**	**DCN or Social Security Number**

Current Mailing Address	**Date of Birth**

City	**State** MO	**ZIP Code**	**Telephone Number**

Interpreter Needed? ☐ Yes ☐ No Language:	Require a reader? ☐ Yes ☐ No	Notices by Email? ☐ Yes ☐ No Email:

Authorized Representative's Name (if you have one)	Authorized Representative's Telephone Number

Authorized Representative's Mailing Address	City	State	ZIP Code

Section B - Programs - Select the program(s) for which you are requesting a hearing.

- ☐ Supplemental Nutrition Assistance Program (SNAP) benefits/claim
- ☐ Temporary Assistance (TA) benefits/claim
- ☐ Missouri SuN Bucks / Summer EBT
- ☐ Low Income Energy or Water Assistance Program benefits/claim
- ☐ MO HealthNet for Age 65, Blind, or Disabled benefits/claim
- ☐ MO HealthNet for Families, Children, CHIP benefits/claim
- ☐ MO HealthNet Adult Expansion Group benefits/claim
- ☐ Blind Pension or Supplemental Aid to the Blind benefits / claim

Please explain why you don't agree with the Agency's action on your case and why you are requesting a hearing. Please be as specific as possible.

SNAP, Temporary Assistance, and MO HealthNet

If you are still certified for SNAP, receiving TA and/or MO HealthNet, and if you request a hearing within 10 calendar days of the date of the Notice of Adverse Action you may choose to continue receiving benefits while your hearing is pending. If the hearing decision shows that the plan to reduce your benefits or close your case was correct, you or your household will be responsible for repaying the amount of benefits you received and were not entitled to receive while your hearing was pending.

If you choose to discontinue receiving benefits while your hearing is pending and the hearing decision is ruled in your favor, any lost benefits will be restored to you.

Please select one of the following options and select the program(s) you are referring to :

While my hearing is pending,

- ☐ **I DO** want to continue receiving: SNAP ☐ TA ☐ MO HealthNet
- ☐ **I DO NOT** want to continue receiving: SNAP ☐ TA ☐ MO HealthNet

I certify under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my knowledge. If signing this electronically, I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

Signature or Electronic Signature of Participant or Authorized Representative	**Date** (MM/DD/YYYY)

HOW TO SUBMIT

Complete and sign this request. Include any supporting documents. Submit in one of four ways:

Email	**IMHearing.FSD@dss.mo.gov**	Save this completed Hearing Request to your computer, then attach it (and any supporting documents)
Fax	**573-526-4554**	Send this completed Hearing Request (and any supporting documents)
Mail	PO Box 2700 Jefferson City MO 65102	
In-Person	**https://dss.mo.gov/dss_map/**	Visit website to locate an office.

SAVE PRINT RESET