MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
REQUEST TO WITHDRAW OR CLOSE

Case Name:	DCN or Social Security Number:	Date:

Physical Address:

Mailing Address (if different):

I wish to voluntarily withdraw my application or close my case for the program(s) checked below:

☐ Supplemental Nutrition Assistance Program (SNAP)	☐ MO HealthNet for Families (MHF)	☐ MO HealthNet for the Aged, Blind, or Disabled (MHABD)
☐ Temporary Assistance (TA)	☐ MO HealthNet for Kids (MHK)	☐ Qualified Medicare Beneficiary (QMB)
☐ MO HealthNet for Pregnant Women (MPW)	☐ MO HealthNet Children's Health Insurance Program (CHIP)	☐ Specified Low Income Beneficiary (SLMB/SLMB2)
☐ Show Me Healthy Babies (SMHB)	☐ MO HealthNet for Adult Expansion Group (AEG)	☐ Blind Pension (BP)
☐ Breast or Cervical Cancer Treatment (BCCT)	☐ MO HealthNet for Uninsured Women (UWHS)	☐ Supplemental Aid to the Blind (SAB)

I wish to remove _____ (Name) from my _____ (Type of Assistance) case/application.

Other specific instructions from the participant:

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.

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 Signature	Date

FSD:

I have explained the eligibility factors, this form, and rights to a fair hearing to the above participant.

FSD:	Date

SAVE PRINT RESET

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. mail:
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. fax:
   (833) 256-1665 or (202) 690-7442; or
3. email:
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.