

Cancel Hearing Request (IM-83) Instructions

Purpose: To provide a method of withdrawing from a State Administrative Hearing. This form is to be used by the applicant, recipient, or their representative who no longer disputes an action proposed, taken, or not taken by the Family Support Division.

Disposition: This form may be completed by the applicant/participant, or their representative.

Instructions for Completion: The entire form is completed by the participant or the participant's representative.

SECTION A: Participant information (required fields are surrounded by a red box):

First Name: This should be the first name of the person the hearing is about.

Middle Initial: This should be the middle initial of the person the hearing is about.

Last Name: This should be the last name of the person the hearing is about.

DCN or Social Security Number: This should be the DCN or Social Security Number for the individual the hearing is about.

Current Mailing Address: Enter the participant's complete mailing street address.

Date of Birth: Enter the participant's complete date of birth.

City: Enter the participant's complete city of their mailing address.

State: This field is pre-populated with MO (Missouri). If the participant's mailing address is in another state, this field will need to be modified to reflect the correct two letter state code.

Zip Code: Enter the participant's complete mailing zip code.

Telephone Number: Enter the participant's complete phone number where they may be reached to conduct a pre-hearing conference.

Interpreter Needed? Select either "Yes" or "No" regarding the participant's need for interpretive services for the hearing. If "Yes" is entered in this field, also list the specific language the participant speaks.

Require a reader?: Does the person this hearing is about need someone to help read the hearing documents? Select either "Yes" or "No".

Notice by E-mail? Select either "Yes" or "No" to indicate if the participant can received their Notice of Hearing and Exhibits for the hearing via email. If "Yes" is entered in this field, also list the email address for the participant.

Authorized Representative's Name (if utilizing one): If applicable, enter the first and last name of the participant's representative or attorney.

Authorized Representative's Phone Number: If applicable, enter the complete ten-digit telephone number of the participant's Authorized Representative.

Authorized Representative's Mailing Address: If applicable, enter the complete mailing address for the participant's Authorized Representative.

City: If applicable, enter the city of the mailing address for the participant's Authorized Representative.

State: If applicable, enter the two letter State code for the participant's Authorized Representative.

Zip Code: If applicable, enter the participant's Authorized Representative's zip code of their mailing address.

SECTION B: Benefits (Select the benefit(s) for which you are requesting a hearing)

The options for the programs are:

SNAP Benefits / claim

Temporary Assistance Benefits / claim

Missouri SuN Bucks / Summer EBT

Low Income Energy or Water Assistance Program / claim

MO HealthNet Benefits Age 65 or Disabled Adult / claim

MO HealthNet Benefits Children and Families / claim

MO HealthNet Adult Expansion Group Benefits / claim

Blind Pension or Supplemental Aid to the Blind benefits / claim

Please indicate why you are requesting your hearing be canceled. (Please be as specific as possible) – Enter the reason you no longer dispute the proposed action or action taken on the participant's benefits.

Signature or Electronic Signature of Requester or Requester's Authorized Representative / Date:

Enter the participant or Authorized Representative's signature (typed name) and the date this request is prepared/submitted.

HOW TO SUBMIT:

Options are provided for the ways the request for a hearing may be submitted to the Family Support Division (e-mail, fax, regular mail, or in-person).