DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF SOCIAL SERVICES

CONFIRMATION OF VOLUNTARY REDUCTION OR TERMINATION OF BENEFITS

Name

Address

County

Case Number

Date

Dear

Your Food and Nutrition Services benefits will be:

☐ reduced to effective

☐ terminated effective

This change is being made because:

_____

Regulations supporting this action are found in Section 635 of the Food and Nutrition Services Certification Manual.

You have a right to a fair hearing of your case if you do not agree with our decision. You can have a fair hearing by letting your local Food and Nutrition Services Office know you want a hearing. You can contact them either in person, by telephone or in writing within 90 calendar days of the date of this letter. The hearing may be requested by any member of your household or by your representative. You can be represented at the hearing by a personal representative, including an attorney you obtain. Free legal services may be available. Contact your nearest Legal Services Office.

To request a hearing, call the Food and Nutrition Services Office at _____
Or fill out and return the form below.

Sincerely,

_____

If you want a fair hearing, fill out this form, tear it off, and mail to:

_____
Name of person requesting hearing

_____

_____

_____

_____
Address

_____

Phone number where you can be reached Signature Today's Date

_____
Use this space to tell us why you want a fair hearing

_____

(For office use only) Caseworker Date Notice Sent Date Received

_____