MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

WAIVER OF 10-DAY ADVANCE NOTICE

TO	**OFFICE**	**DATE** December 27, 2013
	ADDRESS	
FROM	**PARTICIPANT NAME**	**COUNTY**
	ADDRESS	**CASE NUMBER**

My eligibility for _____ has changed because

_____

I understand that, because of this change, my

- ☐ cash benefits will be reduced _____
- ☐ cash benefits will be stopped
- ☐ other: _____

_____

☐ This change will be made on the check I receive beginning with the month of _____ (MONTH) (YEAR)

☐ MO HealthNet coverage will end on _____ (MONTH) (DAY) (YEAR)

for the following persons: _____

By signing this form I am confirming that the eligibility factors have been explained to me and I understand my benefits will cease or be modified as stated above. I further understand I am waiving my rights to a 10 day advance period, during which I could request a fair hearing and have my benefits continue.

I am giving up my right to continue receiving benefits at the present rate if I should request a hearing later.

I understand that I cannot request a hearing until the change is made.

However, I can request a hearing on this decision within 90 days of the date of the notice I receive indicating this change has been made.

DATE	PARTICIPANT SIGNATURE
	➔

STATEMENT OF CASEWORKER

I HEREBY STATE THAT I HAVE EXPLAINED THE ELIGIBILITY FACTORS, THE CONTENTS OF THIS FORM AND RIGHTS TO A FAIR HEARING, TO _____ AND HAVE WITNESSED HIS/HER SIGNATURE ON THE ABOVE DATE.

SIGNATURE OF ELIGIBILITY SPECIALIST	TITLE
➔	