MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

ACTION TAKEN ON YOUR FOOD STAMP CASE

FROM	ELIGIBILITY SPECIALIST	TELEPHONE NUMBER	DATE
	COUNTY OFFICE ADDRESS (STREET)		
	CITY, STATE, ZIP CODE		
TO	NAME		
	ADDRESS (STREET)		
	CITY, STATE, ZIP CODE		
RE	CASE NAME	SUPERCASE NUMBER	CASE DCN

ACTION/REASON

This is to advise you that the following action has been taken on your food stamp case:

☐ Your application has been rejected because you are currently receiving food stamp benefits. Your case will remain active through ____________. You will receive notification advising you when to make reapplication for benefits.

☐ Your request for replacement food stamp benefits has been approved.

☐ Your request for replacement food stamp benefits has been denied because ____________.

CLAIM ACTION

This is to advise you the following action has been taken on your food stamp claim:

☐ Your request for reduction of this claim balance has been approved. The outstanding balance of this claim has been reduced to ____________.

☐ Your request for reduction of this claim balance has been denied. It has been determined a financial, physical, or mental hardship does not exist to reduce the claim balance.

☐ Your request for reduction of this claim balance has been denied because ____________.

If you have any questions about this action, you may call your Eligibility Specialist collect.

If you disagree with this decision, you may request a hearing within 90 days. If you request a hearing:

- you may represent yourself;
- an attorney may represent you;
- other persons who have knowledge of your situation may represent you;
- you have the right to present witnesses in your own behalf; and
- you have the right to question witnesses who appear at the request of the Family Support Division.

For the possibility of free legal services, contact ____________.

If you agree with this decision, you do not have to request a hearing.

SIGNATURE	DATE

If you want a fair hearing, fill out this form, tear it off, and mail or fax it to the county office or call the county office.

NAME OF PERSON REQUESTING A HEARING	TELEPHONE NUMBER
ADDRESS	
TELL US WHY YOU WANT A FAIR HEARING	

DCN	SCN	ELIGIBILITY SPECIALIST	DATE NOTICE SENT	DATE REQUEST RECEIVED