

Section A - Participant Information (required fields are in **bold**)

First Name	Middle Initial	Last Name	DCN or Social Security Number	
Current Mailing Address			Date of Birth	
City	State	ZIP Code	Telephone Number	
Interpreter Needed? Yes No	Require a reader? Yes No	Notices by Email? Yes No		
Language:		Email:		
Authorized Representative's Name (if you have one)			Authorized Representative's Telephone Number	
Authorized Representative's Mailing Address		City	State	ZIP Code

Section B - Programs - Select the programs(s) for which you are requesting a hearing

Supplemental Nutrition Assistance Program (SNAP) benefits/claim	MO HealthNet for Age 65, Blind, or Disabled benefits/claim
Temporary Assistance (TA) benefits/claim	MO HealthNet for Families, Children, CHIP benefits/claim
Missouri SuN Bucks/Summer-EBT (SEBT)	MO HealthNet Adult Expansion Group benefits/claim
Low Income Energy or Water Assistance Program benefits/claim	Blind Pension or Supplemental Aid to the Blind benefits / claim

Please explain why you are requesting your hearing be canceled.

I certify under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my knowledge. If signing this electronically, I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

Signature or Electronic Signature of Participant or Authorized Representative	Date (MM/DD/YYYY)
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HOW TO SUBMIT

Complete and sign this request. Include any supporting documents. Submit in one of four ways:

- Email** IMHearing.FSD@dss.mo.gov Save this completed Hearing Request to your computer, then attach it (and any supporting documents)
- Fax** **573-526-4554** Send this completed Hearing Request (and any supporting documents)
- Mail** PO Box 2700
Jefferson City MO 65102
- In-Person** https://dss.mo.gov/dss_map/ Visit website to locate an office.