CONNECTICUT

Department of Children & Families

NOTICE OF PROPOSED DENIAL, SUSPENSION, REDUCTION, OR DISCONTINUANCE OF BENEFITS
DCF-800
7/2025 (Rev.)

SECTION I (to be completed by DCF Representative)				
Representative LAST Name:	FIRST Name:	E-mail Address:		Phone:
Supervisor LAST Name:	FIRST Name:	E-mail Address:		Phone:
DCF Office: Select DCF Office			Case #	Date Form Mailed:
Child LAST Name:	Child FIRST Name:	Child E-mail:		Child Phone:
C/O Caregiver LAST Name:	Caregiver FIRST Name:	Caregiver E-mail:		Caregiver Phone:
Address (No. and Street):	Apartment #:	City:	State:	Zip:

THIS IS TO NOTIFY YOU THAT THE DEPARTMENT OF CHILDREN AND FAMILIES IS PROPOSING TO:

☐ **SUSPEND** ☐ **DISCONTINUE** ☐ **DENY** effective date:

☐ **REDUCE** from to effective date:

Type of Benefit:	Policy, Statute, Regulation, (must attach) if applicable:

Reason:

IF YOU DISAGREE WITH THE DEPARTMENT'S PROPOSED ACTION, YOU HAVE THE RIGHT TO REQUEST A HEARING.

* If you are presently receiving benefits and you request a hearing within ten (10) days or by _____ your benefit will continue until the end of the payment period in which a hearing decision is made. However, if the decision upholds the Department and the benefit is continued beyond the date of eligibility, you may be asked to reimburse the Department.

* If you do not request a hearing within ten (10) days, your benefit will stop or be reduced but you still have until _____ or sixty (60) days to request a hearing.

* Youth over the age of twenty-one (21), are not eligible for a hearing as continuation in services post-majority is at the sole discretion of the Commissioner.

Complete Page 2 Of This Form If You Wish To Request A Hearing.

THIS SECTION TO BE COMPLETED BY PERSON REQUESTING A HEARING
I hereby request a hearing because:

(You may attach an additional sheet of paper, if necessary)

I understand that I may speak for myself or be represented by legal counsel at my expense or by a relative, friend or other person.

I also understand that I have the right to bring witnesses and any documentary evidence to support my position.

I further understand that the hearing may be rescheduled for good reason and that if I am unable to travel because of age or disabling condition, I may request that the hearing be held at my home.

LAST Name (if different from the person requesting hearing):		FIRST Name:		Phone:
Address (No. and Street):	Apartment #:	City:	State:	Zip:
Name of Person Requesting the Hearing	Signature of Person Requesting the Hearing			Date:
Mail completed form to:	**Department of Children and Families** **Administrative Hearings Unit** **505 Hudson Street** **Hartford, CT 06106**			