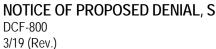
Connecticut Department of Children and Families

NOTICE OF PROPOSED DENIAL, SUSPENSION, REDUCTION, OR DISCONTINUANCE OF BENEFITS





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: Date Form Mailed: Child FIRST Name: Child LAST Name: Case #: 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: effective date: **SUSPEND** DISCONTINUE DENY effective date: from to REDUCE 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. Complete Page 2 Of This Form If You Wish To Request A Hearing.

THIS SECTION T	O BE COMPLE	ETED BY PERSON F	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 repres	sented by legal (counsel at my expense	e or by a relative, friend or ot	her 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 resche request that the hearing be held at my home.	duled for good i	reason and that if I am	n unable to travel because of	age or disabling condition, I may
LAST Name (if different from the person requesting hearing): FIRST Name:			Phone:	
				T Hone.
Address (No. and Street):	Apartment #:	City:	State:	Zip:
ridatess (No. and Guest).	/ tpartmont #:		otato.	Σίγ.
Name of Person Requesting the Hearing	Cian	Lature of Person Requesti	ng the Hearing	Date:
Name of Person Requesting the nearing	Signa	alure of Person Requesti	ng the nearing	Date.
Mail completed for	m to: Donor	tmant of Children or	ad Familias	
Mail completed form to: Department of Children and Families Administrative Hearings Unit				
	505 H	udson Street		
	Hartfo	ord CT 06106		