Connecticut Department of Children and Families

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

DCF-800

3/19 (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			Date Form Mailed:	
Child LAST Name:	Child FIRST 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:

☐ 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.

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