STATE OF WEST VIRGINIA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Waiver of Advance Notice

I have been advised that:

☐ My WV WORKS benefit will be decreased from $ _____ to $ _____ beginning with the _____ (month) payment.

☐ My WV WORKS benefit will be stopped and I will receive my last payment in _____ (month).

☐ The amount of my Food Stamp benefits will be reduced from $ _____ to $ _____ beginning in _____ (month).

☐ My Food Stamp benefits will be stopped and I will receive my last Food Stamp benefits in _____ (month).

☐ My Medicaid will be stopped and I will receive my last medical card in _____ (month).

I wish to waive my right to advance notice of these changes. I understand the reason for this action, which has been fully explained to me, and that I may continue to receive benefits at the current amount next month if I do not waive the advance notice. I do not wish to have a Fair Hearing before this action is taken, although I realize I may request a Fair Hearing at a later date.

Signature	Date	Social Security Number (Optional)

Worker's Signature	Date

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