State of Illinois
Department of Human Services

REQUEST TO WITHDRAW APPEAL

Date: _____

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Case Number: _____

Office Name: _____

NAME: _____

ADDRESS: _____

Office Address: _____

ADDRESS: _____

CITY, ST. ZIP _____

Phone: _____

TTY: _____

Fax: _____

Tenemos este aviso en español. Para solicitar avisos en español, por Internet vaya al sitio ABE-MMC o llame al 1-800-843-6154 (TTY 1-866-324-5553 TTY/ Nextalk, 711 TTY Relay).

You can manage your account online at abe.illinois.gov

If you need help in completing this form, your representative, if you have one, or your DHS or HFS office will assist you.

DHS Program(s) Under Appeal (check all that apply):

☐ SNAP ☐ Medical Eligibility ☐ AABD Cash Assistance ☐ TANF ☐ Child Care

☐ RRA ☐ DASA ☐ DMH ☐ HSP

If you checked one of the boxes above, please file the completed withdrawal at the DHS office or with the DHS Bureau of Hearings at 69 W. Washington, 4th Floor, Chicago, IL 60602, or via email at DHS.BAH@Illinois.gov, Fax at (312) 793-3387.

HFS Program Under Appeal:

☐ Medical Items/Services ☐ Waiver ☐ All Kids ☐ Child Support ☐ HFS Other

If you checked one of the boxes above, please file the completed withdrawal at the HFS office or with the HFS Bureau of Administrative Hearings at 69 W. Washington, 4th Floor, Chicago, IL 60602, or via email at HFS.FairHearings@Illinois.gov, Fax at (312) 793-2005.

Section 1: I filed an appeal requesting a fair hearing because:

_____

_____

Section 2: I have decided to withdraw my appeal and request for a fair hearing because:

_____ IDHS/HFS has agreed to reopen my assistance benefits, make a new decision, and send a new notice.

_____ I now understand the action taken by IDHS/HFS and agree with their decision.

_____ IDHS/HFS has agreed NOT to reduce or cancel my benefits.

_____ Other (Specify) _____

I understand that by withdrawing my appeal, I will not be able to have a fair hearing on this appeal. I also understand that, except for any promises written down in Section (2) above, this form is the complete agreement and I will not be able to appeal this same issue again.

DO NOT SIGN THIS FORM UNLESS IT IS FILLED OUT COMPLETELY AND YOU UNDERSTAND IT.

Your Signature (or Signature of Authorized Representative): _____ Date: _____

IDHS/HFS Representative Signature: _____ Date: _____

For IDHS/HFS Office Use Only: To be completed by IDHS/HFS

Case/Application Name:	Case/Application Number:
Date Request was Received:	Appeal Number: