Connecticut Department of Children and Families
CLIENT'S AGREEMENT TO SUSPEND, REDUCUE, OR TERMINATE DCF BENEFITS
DCF-800A
12/18 (Rev.)

Date:	Client LAST Name		Client FIRST Name:	
Address (No. and Street):	Apartment #:	City:	State: CT	Zip:

I AGREE WITH THE DEPARTMENT'S DECISION TO:

☐ SUSPEND ☐ REDUCE ☐ DISCONTINUE ☐ DENY

Enter effective date:

my Department of Children and Families benefits effective
For the reason(s) stated on the DCF-800, which is attached. I understand that by signing this agreement I do not forfeit my right to a fair hearing on this issue at a later time.

Comments or additional information:

Signature of Client or Caretaker"	Date:
Signature of Social Worker:	Date:

Upon completion please mail this form to:

Please Select DCF Office