TEXAS
Health and Human Services

Form H4827
July 2009-E

Withdrawal of Appeal Request

Name	Case No.
Address (Street, City, State, ZIP Code)	

This is to advise the Texas Health and Human Services Commission that I wish to withdraw my appeal request made on or about _____ regarding the
Date

- ☐ Lowering of benefits
- ☐ Denial of benefits
- ☐ Other: _____

Indicate program(s) you are waiving your right to appeal.

☐ SNAP ☐ TANF ☐ Medical Assistance ☐ Other: _____

I am taking this action of my own free will for the following reason(s):

- ☐ The change in my benefits or eligibility has been explained to me
- ☐ Adjustments to my benefit level accurately reflect my current household circumstances.
- ☐ Existing program policy has been explained to me.
- ☐ Other: _____

I understand that, by signing this document, I waive my right to appeal the action taken; however, I am not waiving my right to appeal any future actions taken by the Texas Health and Human Services Commission.

_____ _____
Signature — Client or Authorized Representative Date

_____ _____
Signature — Employee or Witness Date