Decision date

Write your ID# here

NOTICE OF DECISION

CLIENT ID:

DATE:

FAIR HEARING REQUEST

- - Complete and return this form if you do not agree with this decision.

Today's Date:	Telephone No. (Where You can be Reached)

A good phone number for you

Write the date here

I am requesting a fair hearing for: ☐ **Food Stamps** ☐ **Medicaid** ☐ **TANF**

Select the type of benefits here

By checking this box, I understand I am requesting a fair hearing because I disagree with the decision made on my request for Food Stamps, Medicaid, or TANF. I understand an administrative law judge will listen to the cases presented by both parties and will determine if state and federal law was followed correctly.

Please tell us why you want a fair hearing:

List your reasons for appealing here

Check here if you want benefits to continue

he correct box if applicable:

☐ I do not want to continue receiving the benefits I now receive while waiting for the hearing decision.

☐ I want to continue receiving the benefits I now receive while waiting for the decision. **I understand that I will be required to repay the Department of Human Services any overpayment in benefits to which I was not entitled as determined by the hearing official.** I understand that my benefits may not be continued if my case closed at the end of a period of eligibility or if my application to receive benefits was denied.

Sign here

Today's date

Signature or Mark of Claimant: _____ Date: _____

Please return this completed form to the Department of Family & Children Services

NOTICE OF DECISION

DATE: [redacted]

CLIENT ID: [redacted]

FAIR HEARING REQUEST

- - Complete and return this form if you do not agree with this decision.

Today's Date:	**Telephone No.** (Where You can be Reached)

I am requesting a fair hearing for: ☐ **Food Stamps** ☐ **Medicaid** ☐ **TANF**

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Please tell us why you want a fair hearing:

Check the correct box if applicable:

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Signature or Mark of Claimant: _____ Date _____

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