State of Hawaii
DEPARTMENT OF HUMAN SERVICES

Benefit, Employment and Support Services Division

3 Copies:
1 AAO
1 Client
1 Case File

| FOR DEPARTMENT USE ONLY<br>Case Name: | | |
|---|---|---|
| Cat. & No.: | ☐ Psych | ☐ Physical |
| Unit: | | |
| Date Received: | | |

# REQUEST FOR A HEARING

I. I am asking for a hearing for the following reasons:

A. I DO NOT AGREE with the action taken by the _____ Unit/Office.

[ ] My application was denied.

[ ] My current benefits were reduced or stopped.

[ ] Other (Specify) _____

B. My disagreement is about:

[ ] Financial Assistance [ ] Medical Assistance Benefits [ ] Food Stamp Benefits

[ ] Other Benefits

C. Explain items checked in A & B above: _____

_____

_____

_____

(Write in back if you need more space)

II. **If your hearing request is filed by established deadlines, your benefits will be <u>RESTORED</u> to the amount prior to the notice of termination or reduction of benefits. This means that <u>NO</u> action will be taken to terminate or reduce your benefits until a hearing decision is rendered. If you receive restored benefits <u>AND</u> if the hearing decision upholds the department's action, you will need to <u>REPAY</u> the amounts you received while the hearing decision was pending. For this reason, you may, in Section III below, request <u>NOT TO</u> receive the restored benefits.**

III. If you **<u>DO NOT</u>** want your benefits restored to the amount prior to your notice of termination or reduction of benefits while awaiting your hearing decision, please check the appropriate boxes below:

A. [ ] Financial Assistance Benefits
B. [ ] Medical Assistance Benefits
C. [ ] SNAP Benefits
D. [ ] Other Benefits

IV. I name _____ as my Authorized Representative to represent me and act for me in the Hearing (optional).

_____
(Print Claimant's Name) (Date)

_____ _____
(Claimant's Signature) (Date) (Mailing Address)

_____ _____
(Authorized Representative's Signature –Optional) (Date) (Mailing Address)