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

III. If you DO NOT 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)

DHS 1461 (05/13)