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 Case Name:		
Cat. & No.:	☐ Psychiatric	☐ Physical
Unit:	Date Received:	

REQUEST FOR AN ADMINISTRATIVE 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 [ ] Supplemental Nutrition Assistance Program (SNAP) 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 may be <u>RESTORED</u> to the amount prior to the notice of termination or reduction of benefits. If restored, <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. [ ] SNAP Benefits
C. [ ] Other Benefits

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

_____
(Print Claimant's Name) (Date)

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

_____ _____
(Authorized Representative's (Date) (Print Mailing Address)

DHS 1461 (10/14)