FOR DEPARTMENT USE ONLY

State of Hawaii
Date Request was Received: ______________
DEPARTMENT OF HUMAN SERVICES, Social Services Division
ADULT & COMMUNITY CARE SERVICES BRANCH (ACCSB)
Name of Worker and Phone Number: ______________
Unit Name and Address: ______________
Claimant's Name: ______________
CPSS #: ______________

REQUEST FOR ADMINISTRATIVE HEARING

ADULT & COMMUNITY CARE SERVICES BRANCH, SOCIAL SERVICES DIVISION

Print your Name and Mailing Address: ______________

I would like an Administrative Hearing because I do not agree with the action taken by the Adult & Community Care Services Branch. I do not agree with (check ONE of the following):

[ ] My application for services/payments was denied.

[ ] My current services/payments were reduced or stopped.

[ ] Other (specify): ______________.

Briefly explain: ______________.

If your Administrative Hearing request is filed by established deadlines and you were receiving services/payments, your services/payments will not be terminated or reduced until the Administrative Hearing decision is made. If the Administrative Hearing decision is not in your favor, you will need to repay the amount you received in payments. **If you want your payments to stop while you wait for your Administrative Hearing, place a check mark here [ ].**

You have the right to identify someone to be your Authorized Representative to represent you in the Administrative Hearing. If this is what you want, complete the sentence below.

I want ______________

Print the Individual's Name and Mailing Address

as my Authorized Representative to represent and act for me in this Administrative Hearing.

IF YOU WANT AN ADMINISTRATIVE HEARING:

You must sign this form to complete your request for an Administrative Hearing and you must return this form to the Adult & Community Care Services Unit that is listed above within 90 calendar days of the date of the Notice that your application for services/payments was denied or your current services/payments were being reduced or stopped.

______________ *Your Signature*

______________ *Date*

DHS 1619 (03/07) Original to AAO 1 Copy to Claimant 1 Copy to Case File