State of Illinois
Department of Human Services

APPEAL REQUEST FORM (SNAP, Medical Assistance, Cash Assistance, Child Care)

4cc3362d-9397-48aa-9f84-408acd0faede

Use this form only if you want to file an appeal (this is a request for a hearing). Your Family Community Resource Center (FCRC or local office) may help you fill out this form. You may file this form with your FCRC or with the Bureau of Hearings at 69 W. Washington, 4th Floor, Chicago, IL 60602 or via email at DHS.BAH@Illinois.gov, Fax at (312) 793-3387 or by Telephone at (800) 435-0774.

Appellant First Name	Appellant Last Name	Telephone Number
Address (No. & Street, Apt. No.)	City, County	State, Zip Code
Name Case is Under	Case Number	Social Security Number

Will you need an interpreter in the hearing? ☐ Yes ☐ No If Yes, what language? _____

I am appealing action taken on: (check all that apply) ☐ SNAP ☐ Long Term Care ☐ Medical Assistance ☐ AABD Cash Assistance ☐ TANF ☐ Child Care

Application/Request Date: _____ Department Date of Notice from which you are appealing: _____

I AM REQUESTING A FAIR HEARING BECAUSE:

_____ My application/request was denied and I disagree with this
_____ IDHS says I am not disabled and I disagree with this
_____ I was enrolled in spenddown and I disagree with this
_____ A penalty period was imposed and I disagree with this
_____ I disagree with the benefit amount
_____ I disagree with the beginning eligibility date
_____ My benefits were stopped or reduced and I disagree with this
_____ I was charged with an overpayment and I disagree with this
_____ My SNAP benefits were recouped for a previous overpayment claim(s) and I disagree with this
_____ Money was recovered on an overpayment claim(s) and I disagree with this
_____ A sanction was imposed and I disagree with this
_____ I asked to be exempt from the Department's work and training activities and I was denied
_____ I requested Crisis Assistance and I was denied
_____ IDHS has not taken action on my application or a request

Other Reason: _____

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Please Check One:
Under some programs, benefits may continue while the hearing decision is pending. If possible,

____ I WANT my benefits to continue until the hearing decision is made. I understand that if the decision is not in my favor, I may have to pay back the benefits. I want the following benefits to continue:

☐ Cash ☐ SNAP ☐ Cash and SNAP ☐ Medical Assistance

____ I DO NOT WANT my benefits continued while the hearing decision is pending.

Do you want someone else to represent you at the hearing? If yes, provide their information in the space below.

Approved Representative First Name, Last Name	Telephone Number:	Email Address:
Address (No. & Street, Apt. No.)	City, State, Zip Code	Representative's Firm (if applicable)

(If signed by a person other than the customer, you must attach written authorization to file an appeal on behalf of customer. Please note: the Bureau of Hearings does not have a standardized authorization form and the "Approved Representative Consent Form" (IL 444-2998) is not accepted for appeal representation, as its scope is limited to applying for benefits.)

Your Signature (or Signature of Approved Representative) Date

(if signed by a person other than the customer, attach written authorization to file an appeal on behalf of customer)

Please Note: You are entitled by law to a final decision on your appeal and to full implementation of a decision favorable to you within 90 days from the time you requested the appeal, unless you have requested a delay of your hearing. For SNAP benefits only, you are entitled by law to a final decision on your appeal within 60 days and full implementation of a decision favorable to you within 10 days of receipt of the hearing decision.

For IDHS Office Use Only: To be completed by the FCRC or Hearings

Date Notice of Appeal Received:	Date of Postmark, if mailed (attach envelope):	Date of written request for hearing, if preceding this form:
Date of Decision Being Appealed:	Case Name:	Case Number: