DSS-EA 319 01/06

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF ECONOMIC ASSISTANCE

ORAL/WRITTEN REQUEST FOR ADMINSTRATIVE HEARING

Name of Person Making Request: Date of Request: _____

Address of Person: _____

_____

_____

Telephone Number:

Lawyer or Other Representative (if known):

Case Number: _ Program(s):

Issue(s): _____ DSS Action/Date: _

☐ I want my benefits to continue the same as before this Notice. I understand that if I continue receiving benefits and the Department's action is upheld by the hearing decision, I will have to pay back some or all of the benefits I received while I was appealing the action.

☐ I want my benefits to change as indicated on this Notice. This will prevent my having to pay back benefits that I may not be entitled to receive.

Submitted by: _____

_____
Benefits Specialist

_____
Supervisor

_____
County Office

Sent to OAH:

*The written hearing request (if one submitted) must be attached to this form.