Georgia Department of Human Services

Request for Hearing

I request that the Department of Human Services hold a fair hearing to review the action or inaction of the _____ County Department of Family and Children Services in regard to my claim for assistance as provided under the special assistance program checked below:

□ Temporary Assistance to Needy Families (TANF)

□ Food Stamps

□ Medical Assistance (Medicaid)

□ Other (specify program) _____

The reason I want a hearing is:

_____

_____

_____

_____

_____

Check the correct box if applicable:

□ I do not want to continue receiving the benefits I now receive while waiting for the hearing decision.

□ I want to continue receiving the benefits I now receive while waiting for the hearing decision**. I understand that I may be required to repay the Department of Human Services any overpayment in benefits if I continue receiving benefits the hearing officer later decides I was not entitled to. NOTE: Food Stamp benefits are not continued at the pre-hearing level beyond the next periodic review. If Food Stamp benefits are denied at application or periodic review, they are not continued.**

Date: _____ _____

Signature of Witness

_____ _____

Signature or Mark of Claimant Address of Witness

Please return this completed form to your County Department

(The signature and address of one witness must appear above when the claimant signs with a mark.)

This space for use of State or County Department	**Case Number**	**Date Received**	
		By County	**By State**