State of Illinois
Department of Human Services

8 (3 YEARS)

NOTICE OF APPEAL (Cash Assistance, Medical Assistance, SNAP, Child Care)

I, _____ of _____
Customer Name Street or RFD

_____ _____ _____ _____ _____
City County State Zip Code Telephone Number

am asking for a fair hearing because: (Please state the action or inaction of the Local/Central Department Office that you believe is wrong and why you think it is wrong).

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

FOR CASH/MEDICAL ASSISTANCE (does not apply to Child Care)

◯ I want to continue receiving the assistance benefits I now receive until a decision on my appeal is rendered. I understand that I may owe the value of any financial assistance overpayment I receive while awaiting the decision.

◯ I do not want to continue receiving the assistance benefits I now receive until a decision on my appeal is rendered.

FOR SNAP (Supplemental Nutrition Assistance Program)

◯ I want to continue receiving the amount of SNAP benefits. I now receive until a decision on my appeal is rendered. I understand that I may owe the value of any overissuance I receive while awaiting the decision.

◯ I do not want to continue receiving the amount of SNAP benefits I now receive until a decision on my appeal is rendered.

I want future correspondence about my appeal sent to me in: (check one) ◯ English ◯ Spanish

Your Case Number: _____ Type of Program: _____

My Representative for this appeal, if any, is: _____

_____ _____
SIGNATURE OF CUSTOMER OR AUTHORIZED REPRESENTATIVE **DATE**

(If signed by person other than customer, attach written authorization to file appeal on behalf of customer)

FOR AGENCY OFFICE USE: TO BE COMPLETED BY THE FCRC OR ASSISTANCE HEARINGS

Date this Notice of Appeal was received: _____

Date of Postmark, if mailed (attach envelope): _____

Date of written request for this hearing, if preceding this form: _____

Date of Decision being Appealed: _____

Case Name: _____ Case Number: _____

NOTE: Your Family Community Resource Center (FCRC) will help you fill out this form. Upon completion, file this notice with the FCRC, or with Assistance Hearings, 401 S. Clinton Street, Sixth Floor, Chicago, Illinois 60607. 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 the Supplemental Nutrition Assistance Program 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 the receipt of the hearing decision.

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