State of Alaska
Department of Health and Social Services
Division of Public Assistance

FAIR HEARING REQUEST

This form may be used to request a fair hearing. You, or anyone acting on your behalf, including a Division of Public Assistance employee, may fill out this form.

A request for a fair hearing about Food Stamp benefits may be made to any employee of the Division in person, by telephone, or in writing; fair hearing requests for all other programs must be made in writing.

Please Print

Name: _____

Mailing Address: _____

Telephone Number: _____ Case Number: _____ (If known)

Check the program(s) you want a fair hearing on:

[ ] Food Stamps
[ ] Medicaid
[ ] Alaska Temporary Assistance
[ ] Chronic and Acute Medical Assistance
[ ] General Relief Assistance
[ ] Adult Public Assistance
[ ] Interim Assistance
[ ] Senior Benefits
[ ] Heating Assistance

Please tell us why you are asking for a Fair Hearing:

_____

_____

_____

Please check one box:

☐ Do not stop or reduce my benefits until the hearing decision is made, or my Food Stamp certification period ends. I understand that if the hearing decision is not in my favor, I am responsible for paying back any extra benefits I receive while waiting for the hearing decision.

☐ Take the action to stop or reduce my benefits. I understand that if the hearing decision is in my favor, I will be paid for any benefits incorrectly denied me.

_____ _____
Your Signature (or Authorized Representative Signature) Date

_____ _____
Signature of DPA Employee Date