REQUEST FOR A FAIR HEARING

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT
GOVERNMENT OF GUAM
DIVISION OF PUBLIC WELFARE
BUREAU OF MANAGEMENT SUPPPORT
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☐ **SNAP** ☐ **Cash** ☐ **Medicaid** ☐ **MIP** ☐ **CCDF**

_____ _____

Head of Household Requesting Hearing ***Social Security Number***

_____

Current Mailing Address: (House# or Box #/Village/Zip Code)

_____ _____ _____ _____

Email Address ***Telephone Number (landline)*** ***Telephone Number (Mobil/Cel)*** ***Work Number***

☐ I need DPHSS to provide me with an interpreter at no cost to me.
(A relative or friend cannot interpret for you at the Agency Conference/Fair Hearing)

_____
My language or dialect is:

Reason for requesting hearing:

_____

_____

_____

☐ I would like to waive continuation of my benefits pending the decision of the fair hearing.

☐ I want to continue receiving benefits I was certified eligible to receive pending the Fair Hearing decision. However, If the agency's action is upheld by the Fair Hearing decision, a claim against the household shall be established for all over-issuances.

FOR WORK PROGRAM SECTION DISQUALIFACATION ONLY

☐ I am requesting for a Fair Hearing because I disagree with the disqualification placed on my TANF (cash assistance) benefits. I understand my household will no receive TANF benefits during the disqualification period unless my case is resolved at the Agency Conference or until a Fair Hearing Decision that rules in my favor is received. I understand this in accordance with WPS Policy 2015-05. I also understand I will continue to receive SNAP and medical insurance benefits if eligible, during the disqualification period.

_____ _____ _____

Signature ***Print Name*** ***Date***

REQUEST FOR A FAIR HEARING

For Office Use Only:

_____ _____

Case Number **Date Request Received**

_____ _____

Assigned Case Worker **Date Fair Hearing Notice Sent**

AC Schedule: _____

FH Schedule: _____

AGENCY CONFERENCE RESULTS (TO BE COMPLETED BY FH COORDINATOR & COPY TO BE FWD TO ASSIGNED WORKER

☐ No call/No show to the Agency Conference. Proceed to Fair Hearing.

☐ Appeared for Agency Conference but case unresolved. Proceed to Fair Hearing.

☐ Agency Conference Reschedule to: _____ (for the reschedule AC, please write in results of the AC under "Other.)

☐ Case was resolved at Agency Conference due to (indicate reason- i.e. Individual presented medical disability and is unable to participate)

_____

_____

_____

_____

_____

_____

☐ Other: _____

_____

_____ _____

FH Coordinator Signature ***Date***