

INSTRUCTIONS AND IMPORTANT INFORMATION

1. In order to be accepted, the Department must receive your Request for a Fair Hearing within 30 days of the date on the written notice (90 days for food stamps), unless otherwise specified in the Notice.
2. **If you want your benefits continued while your appeal is pending**, and you are eligible for this service, **you must file your appeal within the first 15 days of the appeal period** and **you must contact your district office**. **Only the district office can start, stop, or adjust your benefits.** The Administrative Appeals Unit cannot start, stop, or continue your benefits. (Continuing benefits while an appeal is pending is not available in all cases.)
3. If you have your benefits reinstated or continued while your appeal is pending and you do not prevail at the hearing, **you will be required to pay back the Department for the benefits you received during the appeal period**.
4. Please fill out the Request for a Fair Hearing **completely**, even if you think we already have that information.
5. If you have questions about why your benefits or services were denied, reduced, or terminated, please contact your district office. **Only the district office can answer those questions**.
6. Please attach a copy of your notice of decision that you are appealing (if applicable) to the Request for a Fair Hearing before submitting it. The scheduling process will be delayed if you do not provide a copy of your notice of decision.
7. Your completed Request for a Fair Hearing (with a copy of the notice attached) may be submitted to your district office, or mailed to the Administrative Appeals Unit at:

Administrative Appeals Unit
Hugh Gallen State Office Complex
105 Pleasant Street, Room 121C
Concord, NH 03301

8. If the Administrative Appeals Unit accepts your Request for a Fair Hearing, a Notice of Hearing will be mailed to you at the address you provided on the Request for a Fair Hearing. The Notice of Hearing will state the date, time, and location for your hearing.
9. You are required to notify the Administrative Appeals Unit of any address or phone number changes while your appeal is pending. If we cannot contact you, your Request for a Fair Hearing may be denied or dismissed without a hearing.

District or Branch Office

REQUEST FOR A FAIR HEARING

READ THESE INSTRUCTIONS BEFORE COMPLETING FORM

If you need help completing this form or wish to verbally request a hearing, contact your District Office.

You or your representative must request a fair hearing, either verbally or in writing, within 30 calendar days of the notice(s) being appealed (90 days for Food Stamps).

If the request is received within 10 days from the date of the notice being appealed, your assistance may, under certain circumstances, be continued or reinstated at the previous level, until the fair hearing decision is issued. **HOWEVER, IF THE FAIR HEARING DECISION GOES AGAINST YOU, CONTINUED OR REINSTATED BENEFITS MUST BE PAID BACK TO THE DIVISION.**

You may represent yourself or be represented by others, including legal counsel. If you need free legal counsel, consult your telephone directory or District Office for the New Hampshire Legal Assistance office nearest you. Contact your representative as quickly as possible to avoid unnecessary delay. **THE DIVISION WILL NOT PAY YOUR LEGAL FEES.**

Complete 1 - 9 below. Sign, and return this form to your District Office. Notification of the scheduled hearing will be mailed to you and your representative at the addresses indicated.

1. Applicant's/Recipient's name: _____ 2. District Office: _____
3. Address: _____ Telephone: Home _____
(STREET/CITY/STATE/ZIP) Work _____
4. Representative's name (if any): _____
5. Address: _____ Telephone: Home _____
(STREET/CITY/STATE/ZIP) Work _____
6. I am dissatisfied with the notice(s), dated _____, as it affects my
- FINANCIAL MEDICAL FOOD STAMP OTHER assistance.

Please explain: _____

7. I want my benefits continued (see instructions above) YES _____ NO _____
8. If you require special accommodations at the hearing due to a disability, handicap or language barrier, please explain: _____

9. SIGN HERE (X) _____ Date: _____
(SIGNATURE OF PERSON MAKING REQUEST)

**IF, AFTER SUBMITTING THIS REQUEST, YOU WISH TO WITHDRAW IT, SEE BACK OF FORM.
KEEP PINK COPY RETURN WHITE AND YELLOW COPIES TO THE DISTRICT OFFICE**

FOR DIVISION USE ONLY—DO NOT WRITE IN THIS SPACE

1. This is a: _____ verbal request made on _____ written request received on _____

2. TYPE OF APPEAL: _____ Financial Assistance _____ Medical Assistance _____
PROGRAM PROGRAM
_____ OMS Determination _____ D.O. Determination
_____ Food Stamps _____ Child Support Services _____ Other _____

3. Date(s) of Notices being appealed (**Please attach**) _____ 4. Will benefits continue at pre-notice level? Yes _____ No _____

5. _____ Date: _____
SIGNATURE, STAFF MEMBER COMPLETING FORM

Forward completed form and Notice of Decision IMMEDIATELY to Office of Fair Hearings.
WHITE—OFFICE OF FAIR HEARINGS YELLOW—DISTRICT OFFICE PINK—CLAIMANT

TO THE APPLICANT/RECIPIENT:

If you no longer want a fair hearing, please sign and enter the date in the spaces below. After completing, return this form to your District Office.

I voluntarily withdraw my request for a Fair Hearing.

SIGNATURE

DATE