Georgia Department of Human Services
Request for Hearing

CLIENT'S NAME (required)	**CLIENT ID**	**DATE OF BIRTH (required)**
DATE (required)	**PHONE NUMBER**	**EMAIL**
ADDRESS (if address has recently changed)		

Client is requesting a fair hearing for:

☐ Food Stamps (SNAP)/Senior SNAP

☐ Medical Assistance

☐ Temporary Assistance for Needy Families (TANF)

☐ Other (specify program) _____

By checking this box, client understands they are requesting a fair hearing because they disagree with the decision made on their request for Food Stamps (SNAP)/Senior SNAP, Medical Assistance, TANF, or LIHEAP. Client understands an administrative law judge will listen to the cases presented by both parties and will determine if state and federal law was followed correctly.

Reason for requesting a hearing:

_____

_____

_____

Check the correct box if applicable:

☐ Client does not want to continue receiving the benefits they now receive while waiting for the hearing decision.

☐ Client wants to continue receiving the benefits they now receive while waiting for the decision**. Client understands that they will be required to repay the Department of Human Services any overpayment in benefits to which they were not entitled as determined by the hearing official.** Client understands that benefits may not be continued if case closed at the end of a period of eligibility or if an application to receive benefits was denied.

☐ Client is requesting a fair hearing due to denial of expedited services.

☐ **For LIHEAP,** client has filed an appeal with the Community Action Agency that serves their county within 60 days from their LIHEAP application date regarding the negative decision rendered by the agency.

☐ Verbal fair hearing request

Signature or Mark of Claimant: (if submitted by Claimant)	
RECEIVED BY:	**DATE:**

Form 118 (Rev. 1/26/2022)