Georgia Department of Human Services
DISPOSITION NOTIFICATION
Work Support Payments
Division of Family and Children Services

Date ____________________

Client's Name ____________________

Client ID #: ____________________

CM's Name/ Phone # ____________________

- [ ] You are approved to receive Work Support Payments of $______per month for_______months starting from:
- [ ] You are ineligible to receive Work Support Payments because:__________________________
- [ ] Your Work Support Payment is terminated effective: ____________________________________
- [ ] You are eligible to receive Transitional Support Services from: __________________ to _______________
- [ ] You are ineligible to receive Transitional Support Services because: ______________________

NOTE: If you fail to comply with the work requirement to receive the Work Support Payment, you will not have the option to revert to TANF before expiration of the twelve (12) months WSP eligibility. You will be ineligible to receive TANF for twelve (12) months.

IMPORTANT INFORMATION:

- **Policy** used to determine your eligibility can be found at **www.odis.dhs.ga.gov.**

- In accordance with Section 504 of the **Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA)**, the **Department of Human Services (DHS)** provides reasonable accommodations to persons with disabilities. This includes help with explaining letters and forms. If you would like a reasonable accommodation or **need help with this form, please contact us at 404-463-5116. If you have a hearing impairment, call GA Relay at 1-800-255-0135**, for free assistance.

- In accordance with Federal laws and State policy, the **Department of Human Services (DHS)** is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, religion or political beliefs.

- **If you need help reading this document** or do not understand English call 1-877-423-4746 for free translation services.

- **You have the right to ask for a fair hearing** before a state hearings officer if you do not agree with this decision. You may be represented at the hearing by a lawyer, relative, friend or anyone you choose. If you want a hearing, you must ask for the hearing in writing or by contacting the agency within:

    - **30 days** from the date of this notice **for TANF**

  If you wish to continue receiving benefits while waiting for your hearing decision you must request the hearing within **14 days** from the date of this notice. Please understand that benefits may not be continued if your case closed at the end of a certification period or if your application to receive benefits was denied. For free legal advice about your benefits please call your local Legal Services office at 1-800-745-5717.

HEARING PROCEDURES

You may be able to get legal help at no cost. If you want a lawyer to help you, you may call one of the numbers below.

1. Georgia Legal Services Program
   1-800-498-9469
   (Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. Office of the State Long-Term Care Ombudsman
   Division of Aging Services
   2 Peachtree Street, NW
   Suite 9-231
   Atlanta, GA 30303-3142
   888-454-LTCO (5826)

3. Atlanta Legal Aid
   404-377-0701 (DeKalb County)
   678-407-6469 (Gwinnett County)
   770-528-2565 (Cobb County)
   404-524-5811 (Fulton County)
   404-669-0233 (So Fulton/Clayton County)

4. Georgia Senior Legal Hotline
   1-888-257-9519
   (Statewide legal services for elderly persons)

FAIR HEARING REQUEST

- Complete and return this form if you do not agree with this decision.

Today's Date	Telephone No. (Where You can be Reached)

I am requesting a fair hearing for: ☐ **Food Stamps/Senior SNAP** ☐ **Medical Assistance** ☐ **TANF**

By checking this box, I understand I am requesting a fair hearing because I disagree with the decision made on my request for Food Stamps/Senior SNAP, Medicaid, TANF. I understand an administrative law judge will listen to the cases presented by both parties and will determine if state and federal law was followed correctly.

Please tell us why you want a fair hearing:

Check the correct box if applicable:

☐ I do not want to continue receiving the benefits I now receive while waiting for the hearing decision.

☐ I want to continue receiving the benefits I now receive while waiting for the decision. **I understand that I will be required to repay the Department of Human Services any overpayment in benefits to which I was not entitled as determined by the hearing official.** I understand that my benefits may not be continued if my case terminated at the end of a period of eligibility or if my application to receive benefits was denied.

You have ten (10) days from the date on the form to request a hearing. All hearing requests must be in writing. Any member of the CAPS program will be glad to provide the necessary forms and assist you with questions regarding the appeal process. You or an authorized representative may represent you during your hearing. You can get information about hearings on the Internet at http://www.ganet.org/osah/.

______________________________ ____________

Signature or Mark of Claimant Date