Georgia Department of Human Services

DISPOSITION NOTIFICATION

Grandparents Raising Grandchildren (GRG) Crisis Intervention Services Payments (CRISP)

_____ County Department of Family and Children Services

_____ _____

Client Name Case Number

_____

Case Manager

_____

Address

_____

PROCEDURES FOR REQUESTING A HEARING ARE ON THE BACK OF THIS FORM

This action is to become effective _____ **FOR FREE LEGAL SERVICES CALL _____**

☐ You have been approved to receive a GRG Crisis Intervention Services Payment (CRISP) of $_____
For: _____.

☐ You are not eligible to receive a GRG Crisis Intervention Services Payment for _____
because: _____

Should you have any questions about your GRG Crisis Intervention Services Payment or your GRG Monthly Subsidy Payment in-eligibility period, please call your case manager at the telephone number listed above.

- **IMPORTANT INF ORM AT IO N:**

  - **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 Modifications and Communication Assistance to persons with disabilities. More information can be found at Notice of ADA/Section 504 Rights. https://dfcs.georgia.gov/adasection-504-and- civil-rights.
  - In accordance with Federal laws and State policy, the **Department of Human Services (DHS)** is prohibited from discriminating based on race, color, national origin, sex, age, disability, and in some cases 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 agencywithin:

    - **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.

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

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 Counties)
   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)

Where the sole issue involved is one of State policy, group hearings may be conducted 42 C.F.R. §431.222.

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** ☐ **Medicaid** ☐ **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, Medicaid or 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.

_____ _____

Signature or Mark of Claimant Date