

HEARING REQUEST FORM

YOUR RIGHT TO A HEARING

You have the right to ask for a hearing if you do not agree with any of our decisions. A hearing is a meeting with you, your caseworker, and a Hearing Officer. The Hearing Officer will listen to the facts and decide if our decision was right or wrong.

At a hearing, you may explain why you do not agree with our decision. You may speak for yourself or have someone else, such as a friend or relative, speak for you. You may also have an attorney speak for you. You may call Legal Services at 1-800-453-3320 to ask about free legal help.

The best way to ask for a hearing is to use the HEARING REQUEST FORM. If you are asking for a hearing for the Food Stamp program, you can also call 1-800- 462-0134.

- You have **60 days** from the date of this notice to ask for a hearing **for all programs except** Food Stamps.
- The Food Stamp program has a time limit of **90 days** to ask for a hearing.

For HUSKY A or MEDICAID

- If you are in a Medicaid Spenddown, your benefits may not continue.
- Your benefits will not change if you ask for a hearing before the effective date of this change.
- If the Hearing Officer decides our change was right, you may have to pay us back.
- If the Hearing Officer decides we were wrong, we will pay for any covered health care.

Other Programs

- Your benefits will not change if you ask for a hearing within 10 days of this notice. Your benefits will stay the same until the Hearing Officer decides.
- If the Hearing Officer decides our change was right, you may have to pay us back.
- If you let us change your **cash benefits** and the Hearing Officer decides our change was wrong, we will immediately pay you all the benefits we owe you.
- If you are in the **Temporary Family Assistance** program, there may be a time limit. You can ask for a hearing at the end of the time limit, but your benefits will stop at the end of the time limit even if the hearing has not yet been held or decided.

KEEP THIS PAGE FOR YOUR RECORDS

YOU HAVE THE RIGHT TO MAKE A DISCRIMINATION COMPLAINT

You have the right to make a discrimination complaint if you think we have taken action against you because of your race, color, religious creed, sex, marital status, age, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, learning disability or physical disability, including but not limited to blindness.

An individual with a disability may request and receive a reasonable accommodation or special help from the department when special help is necessary to allow the individual to have an equal and meaningful opportunity to participate in the programs administered by the department.

If you asked for an accommodation or special help and we refused to provide the special help, you may make a complaint to the department's Affirmative Action Division Director or any of the agencies listed below.

You or someone representing you can write to or call one or more of these agencies to make a discrimination complaint:

Commissioner of the Department of Social Services

Attention: Affirmative Action Division Director/ADA Coordinator,
25 Sigourney Street
Hartford, CT 06106-5033
Telephone: 1-860-424-5040 (TDD: 1-800-842-4524)

Connecticut Commission on Human Rights and Opportunities

21 Grand Street
Hartford, CT 06106
Telephone: 1-860-541-3400 (TDD: 1-860-541-3459)

US Department of Health and Human Services

Office of Civil Rights, Region 1

JFK Federal Building, Room 1875
Boston, MA. 02203
Telephone: 1-617-565-1340 (TDD: 1-617-565-1343)

US Department of Agriculture

Office of Civil Rights (Food Stamps only)

Whitten Building, Room 326-W
1400 Independence Avenue SW
Washington D.C. 20250-9410
Telephone/TDD: 1-202-720-5964

Name: _____

Client I.D.: 00 _____

Address: _____

Worker Name: _____

HEARING REQUEST FORM

Use this form only if you want a hearing. Remember, before you ask for a hearing or at any time afterwards, you may call your caseworker or his/her supervisor for help in solving the problem:

1. I do not agree with the decision taken on my case. I am requesting a hearing because:

(Please use the back of this form if you need more room to write.)

2. My telephone number, including area code is: () _____

3. Please check one:

Under some programs, benefits may continue while the hearing decision is pending. If possible, I want my benefits to continue until the hearing decision is made. I understand that if the decision is not in my favor, I may have to pay back the benefits.

I do not want my benefits continued while the Hearing Officer is deciding.

4. X _____ Date _____
Signature

5. Mail or fax this completed request to:

Department of Social Services
Office of Legal Counsel, Regulations and Administrative Hearings
25 Sigourney Street
Hartford, CT 06106-5033
Fax Number: (860) 424-5729

