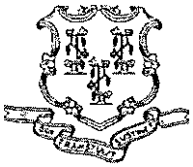
STATE OF CONNECTICUT  DEPARTMENT OF SOCIAL SERVICES

03-000003 000014

Date:

Client ID:
To contact us please call
Monday-Friday 7:30-4:00
DSS Benefit Center

Toll Free: 1-855-626-6632
Office:

HEARING REQUEST FORM

Use this form only if you want a hearing. Remember: Before you ask for a hearing, you may call the Benefit Center 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 do not leave blank and use the back of this form if you need more room to write.)

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

3. If you were getting benefits before you received the DSS notice and you request a hearing within 10 days of that notice (or, for Medicaid, any time before the date the action becomes effective), we will keep your benefits as they were until the Hearing Officer decides your case. If the hearing decision is not in your favor, you may need to pay DSS back for these benefits.

   [ ] Please check this box if you DO NOT want to keep getting your benefits as they were while the Hearing Officer decides your case.

4. _____ _____
   Signature **Date**

5. Mail or fax this completed request to:

   Department of Social Services
   Office of Legal Counsel, Regulations and Administrative Hearings
   55 Farmington Avenue
   Hartford, CT 06105
   Fax Number: (860) 424-5729

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR, TDD/TTY (800) 842-4524.

Client ID:

Office: