MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPLICATION FOR STATE HEARING

1. CATEGORY BEING APPEALED

☐ 1619	☐ LIHEAP	☐ MHABD-VEN	☐ MOCDD (Sara Lopez Waiver)	☐ SLMB	☐ SUPP AB
☐ BCCT	☐ EMCIA	☐ MHCC	☐ MPW	☐ SNC	☐ TEMP ASSIST
☐ BP	☐ EWHS	☐ MHDC	☐ PE For Kids/Pregnant Women	☐ SP	☐ TWHA
☐ CC	☐ FS	☐ MHF	☐ QDWI	☐ SSI	☐ UWHS
☐ CCP	☐ MHABD	☐ MHK	☐ QMB	☐ SSI-SP	☐ OTHER

2. DWD(METP)	2.a MWA	3. SANCTIONED INDIVIDUAL (FOR DWD/MWA HEARING)	4. SSN OF SANCTIONED INDIVIDUAL (DWD/MWA HEARING)
☐ Yes ☐ No	☐ Yes ☐ No		- -

5. CASE NAME	6. CASE DCN	7. CASE RESIDENCE COUNTY	8. FSD OFFICE OF ACTION

9. CLAIMANT IS APPEALING (CHECK ONE)	10. DATE OF ACTION NOTICE FOR WHICH HEARING IS REQUESTED	11. DATE HEARING REQUESTED
☐ REJECTION ☐ GRANT AMOUNT/ISSUANCE ☐ CLOSING ☐ DELAY ☐ OTHER		

12. NAME AND DCN OF PERSON THE HEARING IS FOR OR ABOUT, IF DIFFERENT THAN CASE NAME

13. REASON FOR PLANNED ACTION OR DECISION BY AGENCY

COMPLETED BY CLAIMANT

14. NAME OF THE PERSON REQUESTING THIS HEARING (REFERRED TO AS CLAIMANT)	15. TELEPHONE NUMBER - -

16. HOUSEHOLD MAILING ADDRESS (STREET, RURAL ROUTE, OR P O BOX, CITY, STATE, ZIP CODE)

STATE OF MISSOURI, I hereby make application for a hearing provided by state law or department regulations.

17. CLAIMANT: STATE PLAINLY THE REASON YOU ARE REQUESTING A HEARING.

18. FOOD STAMP, TEMPORARY ASSISTANCE AND/OR MO HEALTHNET RECIPIENTS

If you are still certified for Food Stamps (FS), receiving Temporary Assistance (TA) and/or MO HealthNet, if you request a hearing within 10 calendar days of the date of the Notice of Adverse Action you may choose to continue receiving benefits while your hearing is pending. If the hearing decision shows that the plan to reduce your benefits or close your case was correct, you or your household will be responsible for repaying the amount of benefits you received and were not entitled to receive while your hearing was pending. If you elect to discontinue receiving benefits while your hearing is pending and the hearing decision is ruled in your favor, any lost benefits will be restored to you.

Please check one of these boxes:

19. I wish to continue receiving ☐ FS ☐ TA ☐ MO HealthNet while my hearing is pending.

20. I do not wish to continue receiving ☐ FS ☐ TA ☐ MO HealthNet while my hearing is pending.

COMPLETED BY AGENCY

26. ES or ESS THAT WILL BE AGENCY WITNESS:

NAME: TELEPHONE: EXT:

NORMAL DAILY WORK SCHEDULE:	
Monday	to
Tuesday	to
Wednesday	to
Thursday	to
Friday	to

UPCOMING SCHEDULED TIME OFF:	
Date(s)	to
Date(s)	to
Date(s)	to
Date(s)	to

21. CLAIMANT'S REPRESENTATIVE: NAME	22. REPRESENTATIVE TELEPHONE NUMBER - -

23. CLAIMANT'S REPRESENTATIVE: ADDRESS

24. CLAIMANT'S SIGNATURE (OR SIGNATURE OF CLAIMANT'S REPRESENTATIVE)	25. DATE

COMPLETED BY AGENCY

27. DATE HEARING REQUEST SCANNED AND EMAILED TO HEARINGS UNIT	28. DATE EXHIBITS OR FOLLOW-UP DOCUMENTS MAILED TO HEARINGS UNIT
29. SIGNATURE OF ELIGIBILITY SPECIALIST	31. ES or ESS will be participating from FSD office.
30. SIGNATURE OF SUPERVISOR	32. Claimant will be participating from FSD office.
	33. DATE IM-87 RECEIVED BY HEARINGS UNIT _____