



State of Alaska
Department of Health and Social Services
Division of Public Assistance

FAIR HEARING REQUEST

This form may be used to request a fair hearing. You, or anyone acting on your behalf, including a Division of Public Assistance employee, may fill out this form.

This form is not required to ask for a fair hearing. A fair hearing may also be requested by phone, or in person.

Please Print

Name: _____

Mailing Address: _____

Telephone Number: _____

Case Number: _____
(If known)

Check the program(s) you want a fair hearing on:

- [] Food Stamps [] Adult Public Assistance
[] Medicaid [] Interim Assistance
[] Alaska Temporary Assistance [] SeniorCare
[] Chronic and Acute Medical Assistance [] Heating Assistance
[] General Relief Assistance

Please tell us why you are asking for a Fair Hearing:

Four horizontal lines for text entry.

Please check one box:

- [] Do not stop or reduce my benefits until the hearing decision is made, or my Food Stamp certification period ends. I understand that if the hearing decision is not in my favor, I am responsible for paying back any extra benefits I receive while waiting for the hearing decision.
[] Take the action to stop or reduce my benefits. I understand that if the hearing decision is in my favor, I will be paid for any benefits incorrectly denied me.

Your Signature (or Authorized Representative Signature)

Date

Signature of DPA Employee

Date