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.
A request for a fair hearing about Food Stamp benefits may be made to any employee of the Division in person, by telephone, or in writing; fair hearing requests for all other programs must be made in writing.

Please Print

Name: ____

Mailing Address: ____

Telephone Number: __________________ Case Number: _______________________
(If not known, enter Date of Birth)

Check the program(s) you want a fair hearing on:
[ ] Food Stamps [ ] Adult Public Assistance
[ ] Medicaid [ ] Interim Assistance
[ ] Alaska Temporary Assistance [ ] Senior Benefits
[ ] Chronic and Acute Medical Assistance [ ] Heating Assistance
[ ] General Relief Assistance

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

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

____
Representative's name and contact information

_______________________________________ ____________________
Signature of DPA Employee Date