

**COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES**

APPEAL TO STATE DEPARTMENT OF SOCIAL SERVICES

TO

HEARING AND LEGAL SERVICES MANAGER
VIRGINIA DEPARTMENT OF SOCIAL SERVICES
801 EAST MAIN STREET
RICHMOND, VIRGINIA 23219-2901

COUNTY/CITY
CASE NUMBER
NAME
ADDRESS
CITY, STATE, ZIP

TO BE VALID/TIMELY, FOOD STAMP APPEALS MUST BE RECEIVED WITHIN 90 DAYS OF WRITTEN NOTICE OF THE LOCAL AGENCY DECISION. ALL OTHER APPEAL REQUESTS MUST BE RECEIVED WITHIN 30 DAYS OF WRITTEN NOTICE OF THE LOCAL AGENCY DECISION. ALL APPEAL REQUESTS MUST MEET APPROPRIATE DEADLINES AS REQUIRED BY LAW. THERE IS NO REQUIREMENT THAT MY REQUEST FOR AN APPEAL IN FOOD STAMPS OR TANF BE MADE IN WRITING. THE REQUEST MAY BE ORAL.

MY APPEAL IS IN REGARD TO THE FOLLOWING PROGRAM(S):

- | | |
|---|--|
| <input type="checkbox"/> TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)
<input type="checkbox"/> FOOD STAMPS
<input type="checkbox"/> GENERAL RELIEF
<input type="checkbox"/> AUXILIARY GRANTS | <input type="checkbox"/> ENERGY ASSISTANCE (LIMITED TO ITEMS WITH "*" ASTERISK)
<input type="checkbox"/> SERVICES (e.g., ADULT SERVICES, CHILD CARE)
<input type="checkbox"/> REFUGEE CASH ASSISTANCE
<input type="checkbox"/> REFUGEE MEDICAL ASSISTANCE
<input type="checkbox"/> OTHER _____ |
|---|--|

ATTENTION:

ACCORDING TO THE PROVISIONS OF THE VIRGINIA PUBLIC WELFARE AND ASSISTANCE LAW, AS AMENDED, I DO HEREBY APPEAL FOR A REVIEW OF THE (PROPOSED) ACTION OF THE DEPARTMENT OF SOCIAL SERVICES IN THE COUNTY/CITY OF: _____ FOR THE REASON(S) CHECKED BELOW:

<input type="checkbox"/> REFUSAL TO TAKE MY APPLICATION FOR ASSISTANCE OR SERVICES*	<input type="checkbox"/> REFUSAL TO TAKE MY APPLICATION FOR FOOD STAMPS	<input type="checkbox"/> DECLARING ME INELIGIBLE FOR ASSISTANCE OR SERVICES*	<input type="checkbox"/> DECLARING MY HOUSEHOLD INELIGIBLE TO PARTICIPATE IN THE FOOD STAMP PROGRAM
<input type="checkbox"/> SUSPENDING MY ASSISTANCE OR SERVICES		<input type="checkbox"/> CANCELING MY ASSISTANCE OR SERVICES*	<input type="checkbox"/> CANCELLING MY FOOD STAMPS
<input type="checkbox"/> FAILURE TO TAKE ACTION ON MY REQUEST FOR AN INCREASE IN MY ASSISTANCE OR SERVICES WHICH WAS MADE ON: _____ DATE _____	<input type="checkbox"/> FAILURE TO PROVIDE EXPEDITED SERVICE ON MY FOOD STAMP CASE	<input type="checkbox"/> FAILURE TO RENDER A DECISION ON MY APPLICATION FOR ASSISTANCE OR FOOD STAMPS WITHIN THE ALLOWABLE TIME LIMIT: * APPLICATION WAS MADE ON: _____ DATE _____	
<input type="checkbox"/> AWARDED ME INSUFFICIENT ASSISTANCE OF \$ _____	<input type="checkbox"/> DECREASING MY FOOD STAMP ALLOTMENT	<input type="checkbox"/> DECREASING MY ASSISTANCE FROM \$ _____ TO: \$ _____ <input type="checkbox"/> DECREASING MY SERVICES _____ FROM _____ DAYS/HOURS TO _____ DAYS/HOURS	

OTHER (EXPLAIN) _____

I BELIEVE I AM ELIGIBLE FOR ASSISTANCE, SERVICES, OR FOOD STAMPS OR AN INCREASE IN ASSISTANCE OR SERVICES OR ADJUSTMENT IN FOOD STAMPS BECAUSE:

I UNDERSTAND THAT ANY ASSISTANCE AND/OR FOOD STAMP BENEFITS RECEIVED UNTIL A HEARING DECISION IS GIVEN MUST BE REPAYED TO THE AGENCY IF THE HEARING DECISION SUPPORTS THE ACTION BEING PROPOSED BY THE AGENCY.

I WISH MY FOOD STAMP BENEFITS TO CONTINUE UNTIL A HEARING DECISION IS RENDERED: YES NO

I WISH MY ASSISTANCE OR SERVICES TO CONTINUE UNTIL A HEARING DECISION IS RENDERED: YES NO

I RECEIVED A WRITTEN NOTICE FROM THE SOCIAL SERVICES DEPARTMENT ON (DATE)	NAME/ADDRESS/TELEPHONE OF CLAIMANT'S LEGAL REPRESENTATIVE (IF SELECTED)
CLAIMANT SIGNATURE	DATE

APPEAL TO STATE BOARD OF SOCIAL SERVICES

FORM NUMBER - 032-03-0024-09-eng

PURPOSE OF FORM – To appeal a case decision.

USE OF FORM – To be completed by the claimant or representative who is appealing the decision, with help from the agency, if necessary.

NUMBER OF COPIES – Original only.

DISPOSITION OF FORM – Send to the address on the form.

INSTRUCTIONS FOR PREPARATION OF FORM – All information applicable to the issue being appealed and the date the written notice was received must be completed. The form is signed and dated by the claimant.