

DISTRICT OF COLUMBIA
Office of Administrative Hearings
441 4th Street, NW, Suite 450-North
Washington, DC 20001

REQUEST FOR A HEARING IN A PUBLIC BENEFITS CASE

Section 1 I am a(n): **APPLICANT** for benefits **RECIPIENT** of benefits

I am requesting a hearing because I disagree with the action(s) regarding the following program(s):

- | | |
|---|---|
| <input type="checkbox"/> Food Stamps (FS) | <input type="checkbox"/> Medicaid DC (MA) |
| <input type="checkbox"/> Interim Disability Assistance (IDA) | <input type="checkbox"/> General Assistance for Children (GAC) |
| <input type="checkbox"/> Energy Assistance (EA) (DPW/Office of Energy) | <input type="checkbox"/> Program on Work, Employment & Responsibility (POWER) |
| <input type="checkbox"/> Rehabilitation Services (RSA) | <input type="checkbox"/> Emergency Shelter (SHELTER) |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Other (please specify) _____ | |

Section 2 Reason(s) For Disagreeing with Agency's action: (additional space on back if needed) _____

Section 3 What do you want the judge to do? (additional space on back if needed) _____

Section 4 **DOLLAR AMOUNT** of any benefits or assistance that you are seeking (please check one): maximum benefit for my household size, or \$ _____ per month in benefits **OR** The overpayment amount I believe I should not have to pay (\$ _____)

Section 5 Do you require special services of any kind to help you participate in the hearing? (Language translation, sign language interpreter, etc.) Yes No If Yes, what service is required? _____

Section 6 – Contact Information

Name of Applicant/Recipient (please print): _____ **Date:** _____

_____ **Case No.:** _____

Address: _____ **Case Worker:** _____

City, State, Zip: _____ **Center:** _____

Telephone No.: _____ **Telephone No.:** _____

Signature: _____ **Supervisor:** _____

Number of People in Household: _____ **Center Manager:** _____

Attorney/Representative (if any): _____ **Person preparing request (if other than applicant):** _____

Name: _____ **Print name:** _____

Address: _____ **Signature:** _____

City, State, Zip: _____ **Office/Center (if DHS):** _____

Telephone No.: _____ **Telephone No.:** _____

COMPLETE AND SUBMIT A CERTIFICATE OF SERVICE ON THE BACK OF THIS FORM CERTIFYING THAT YOU HAVE SERVED AGENCY REPRESENTATIVES WITH THIS HEARING REQUEST. THE SUBMISSION OF A FALSE STATEMENT ON THIS FORM OR THE CERTIFICATE OF SERVICE IS A CRIME PUNISHABLE UNDER D.C. OFFICIAL CODE § 22-2405.

[Add Additional Documentation as Needed or Use Writing Space Below]

CERTIFICATE OF SERVICE

I certify that a copy of this document was served by: First-Class Mail Hand Delivery Fax to the APPLICANT/RECIPIENT on the reverse (if prepared by someone other than the applicant/recipient), on the General Counsel, **and** on any program checked below (you must check each program checked on the reverse).

Signature

Date

For the General Counsel's Office:

Monica J. Brown, Esq.
Department of Human Services
Office of the General Counsel
64 New York Avenue, NE 6th Floor
Washington, DC 20002
FAX: (202) 671-4454

For Rehabilitation Services:

James Tolbert
Department of Human Services
Rehabilitation Services Administration (RSA)
810 First Street, N.E. - 10th Floor
Washington, DC 20002
FAX: (202) 279-6014

For FS, IDA, MA, GAC, TANF, POWER:

Ellen Wells
Department of Human Services
Income Maintenance Administration (IMA)
645 H Street, NE, Suite 5000
Washington, DC 20002
FAX: (202) 724-2041

For Emergency Shelter:

Keith Cross, Deputy Director
Department of Human Services
Office of the General Counsel
64 New York Avenue, NE 6th Floor
Washington, DC 20002
FAX: (202) 671-4326

For Energy Assistance:

Keith Anderson
D.C. Energy Office
2000 14th Street, NW, 300 East
Washington, DC 20009
FAX: (202) 673-6725

For Child Care:

Barbara Kamara
Executive Director
Office of Early Childhood Development
717 14th Street NW
Washington, DC 20005
FAX: (202) 724-7228