

**DISTRICT OF COLUMBIA**  
**OFFICE OF ADMINISTRATIVE HEARINGS**  
One Judiciary Square  
441 Fourth Street, NW, Suite 450N  
Washington, DC 20001-2714  
TEL: (202) 442-9094 · FAX: (202) 442-4789

**REQUEST FOR A HEARING IN A DEPARTMENT OF HUMAN SERVICES CASE**

**SECTION 1 – CONTACT INFORMATION**

**Name of Applicant/Recipient** (please print): \_\_\_\_\_

DHS Case Number (if known) \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Who provided the information to OAH?** \_\_\_\_\_ Petitioner \_\_\_\_\_ Family Member \_\_\_\_\_ Other Representative

**SECTION 2 – BENEFIT INFORMATION**

Petitioner is a(n): \_\_\_\_\_ **APPLICANT** for benefits

\_\_\_\_\_ **RECIPIENT** of benefits

Petitioner is requesting a hearing because he/she disagrees with agency action(s) regarding the following program(s):

\_\_\_\_ Food Stamps (FS) \*Please complete Section 3\*

\_\_\_\_ Child Care

\_\_\_\_ Medicaid (MA)

\_\_\_\_ General Assistance for Children (GAC)

\_\_\_\_ Temporary Assistance for Needy Families (TANF)

\_\_\_\_ Program on Work, Employment & Responsibility (POWER)

\_\_\_\_ Other (please specify) \_\_\_\_\_

\_\_\_\_ Burial Assistance

**SECTION 3 - FOR FOOD STAMPS CASES ONLY: PLEASE CHECK ONE OF THE FOLLOWING BOXES**

I want my benefits to be reduced or cut off while I wait for my hearing decision, even though I am eligible to keep them the same while my hearing is pending.

I want my benefits to stay the same while I wait for my hearing decision, if allowed. I know that I will need to repay my benefits if I do not attend or lose the hearing.

**SECTION 4 – AGENCY ACTION TAKEN**

What kind of action has the agency proposed?

\_\_\_\_ Denial of application for benefits

\_\_\_\_ Denial of specific service

\_\_\_\_ Termination of benefits

(please specify) \_\_\_\_\_

\_\_\_\_ Reduction of benefits

\_\_\_\_ Other

\_\_\_\_ Finding of overpayment

(please specify) \_\_\_\_\_

**SECTION 5 – ACCOMMODATIONS**

Does the Petitioner require special services of any kind at the hearing? (Language translation, sign language interpreter, etc.)

\_\_\_\_ Yes

\_\_\_\_ No

If Yes, what service is required? \_\_\_\_\_

**SECTION 6 – ATTORNEY, FAMILY MEMBER,**

**OTHER REPRESENTATIVE (IF ANY)**

**Name:** \_\_\_\_\_

**Relationship to Petitioner:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Telephone No.:** \_\_\_\_\_

**SECTION 7 – CLERK’S OFFICE CERTIFICATION**

**(COMPLETE ONLY IF PETITIONER WAS ASSISTED)**

**I CERTIFY THAT THE INFORMATION ON THIS FORM IS A SUMMARY OF AN ORAL REQUEST TAKEN BY PHONE OR IN PERSON.**

**Clerk Name:** \_\_\_\_\_

**Signature and Date:** \_\_\_\_\_

**Hearing Request Taken** \_\_\_\_\_ **By Telephone** \_\_\_\_\_ **In Person**