REQUEST FOR HEARING

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 162 (5-2023)

Clear Fields

This process is available to appeal an adverse determination made by the Department of Health and Human Services.

I am appealing a decision made by:

Program Name

APPEAL OF:

Name		Telephone Number	
Address	City	State	ZIP Code

STEP 1: ATTACH THE NOTICE THAT YOU ARE CONTESTING.

STEP 2: EXPLAIN THE ERROR THAT YOU CLAIM WAS MADE. Attach additional sheets if needed.

STEP 3: FOR RECIPIENTS APPEALING ECONOMIC ASSISTANCE BENEFITS:

☐ **I want to continue receiving _____ benefits at the previous benefit level.**

I understand that I may continue to receive benefits pending the outcome of the fair hearing. However, if the fair hearing official's decision is not in my favor, all adult members in my household will be held liable for any overissuances received while awaiting the outcome of the fair hearing. Applicants who are denied benefits at initial certification or because of the expiration of their certification may appeal the denial, but cannot receive benefits while awaiting the outcome of the hearing.

☐ **I do not want to continue receiving _____ benefits at the previous benefit level.**

STEP 4: Complete this part only if you will have someone such as an attorney, relative or other person of your choosing, assist you in your appeal.

I authorize the person named below to assist me in my appeal:

Name		Telephone Number	
Address	City	State	ZIP Code

STEP 5: SIGN AND DATE:

Signature	Date

STEP 6: Transmit this Request for Hearing to Appeals Supervisor, Department of Health and Human Services, 600 E. Boulevard Ave., Dept. 325, Bismarck, ND 58505-0250; fax number (701) 328-2173; email: dhslau@nd.gov or deliver to your local Human Service Zone Office. The method of transmittal must follow the program rules.