APPEAL BACKGROUND REPORT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 1784 (5-2023)

Clear Fields

Client Name	
Case Number	

1. PLEASE ATTACH A COPY OF THE ACTION NOTICE THAT IS BEING APPEALED AND COMPLETED REQUEST FOR HEARING FORM (SPACES, etc.).

2. Action taken: (check applicable box(es))

- ☐ Application Denied
- ☐ Assistance Discontinued
- ☐ Benefits Reduced
- ☐ Other: _____

3. Program

- ☐ TANF
- ☐ SNAP
- ☐ Medical Assistance
- ☐ Fuel Assistance
- ☐ Other: _____

4. Identify the section(s) of the manual or administrative code you relied on, with a brief summary of the applicable language.

5. What was the reason for the action you took and what information did you rely on? (Use reverse side if necessary.) Provide a detailed explanation.

6. Is the client's disagreement with:

- ☐ The information that was relied on in making the decision
- ☐ The program regulations that were applied in this case
- ☐ Other: _____
- ☐ Unknown

Submitted By	Date