

Appendix G
Request for Fair Hearing

Request for Fair Hearing

Division of Hearings, DTA
Schraft Building
529 Main Street
Charlestown, MA 02129

FAX: 1-617-241-2535

DATE: _____

Dear Persons:

This letter is to request a fair hearing to challenge the termination/denial of my public assistance _____ benefits. I received a notice which stated my benefits would end on: _____ (date). I am requesting a fair hearing because:

_____ (reason).

I further request that my benefits be continued/reinstated pending this appeal.

When scheduling my appeal, please note the following (check items that apply):

- I have appointed the following person/organization to represent me at the hearing. Please send them a copy of the notice of the hearing date. They also have the authority to inspect my files and discuss my case with any Department representative.

Name: _____ Phone: _____

Organization: _____

Address: _____

- I will need a translator at the hearing who is fluent in English and _____ (list language, including sign language if needed).
- I request that the hearing be held at my home because I am disabled and homebound. I am unable to attend a hearing at the local Welfare Office.
- I am unable to attend a hearing at the following times or dates: _____ . Please schedule the hearing for a time when I am able to attend.

Thank you for your attention to this request.

Signed: _____

Print Name: _____

Phone: _____

Street: _____

City/Town: _____

SSN (if known) _____

Worker(if known) _____