DHS-121
Rev.10-14

Agency Date Stamp

RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES

Hearing Office Date Stamp

REQUEST FOR A HEARING

SECTION I. IDENTIFYING INFORMATION – Please Print

Name _____ _____
Recipient Social Security Number

Address _____
Number and Street City/Town State ZIP

WHAT LANGUAGE DO YOU SPEAK? _____

SECTION II. STATEMENT OF COMPLAINT (To be completed by applicant or recipient)

MY APPEAL IS ABOUT: ____ RIW ____ MEDICAID ASST. ____GPA
____ SNAP ____ CHILD CARE _____ OTHER

_____

_____

_____

_____

_____

IF THE HEARING DECISION IS NOT IN MY FAVOR, I UNDERSTAND THAT I MUST REPAY ANY ASSISTANCE AND/OR FOOD STAMPS FOR WHICH I AM DETERMINED INELIGIBLE.

Signature _____ Date _____
(Recipient)

SECTION III. STATEMENT OF AGENCY POLICY (To be completed by the Agency Representative)

THE APPEAL IS ABOUT: ____ RIW ____ MEDICAID ASST. ____GPA
____ SNAP ____ CHILD CARE ____ MART DECISION

Indicate Specific DHS/FS Manual Reference: Section(s) _____ _____

Explain agency decision in relation to complaint and policy: _____

_____

_____

_____

_____ _____
Agency Representative (Signature) **Supervisor (Signature)**
(Print Name)_____ **(Print Name)**_____

Regional Manager _____ **Local Office** _____

Also Send Copies of the scheduled appointment for this Hearing Request to: _____ _____

_____ _____ _____ _____

AGENCY:
MA DISABILITY ONLY CASES: Attach Copy of InRhodes Adverse Action Notice
ALL OTHER CASES: Bring Notice to Hearing