ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

HEARING REQUEST

See Page 6 for your appeal rights and information on how to file an appeal

CLIENT INFORMATION

Name *(Last, First, M.I.)*:

_____

HEAplus Application ID:

_____

AZTECS Case Number:

_____

Address *(No., Street)*:

_____

City: _____

State: _____ **ZIP Code:** _____

See page 10 for USDA/EOE/ADA disclosures

Phone Number *(Include Area Code)*:

I want to appeal for the following programs: *(Check box)*

- ☐ **Cash Assistance**
- ☐ **Nutrition Assistance**
- ☐ **Medical Assistance**
- ☐ **Tuberculosis Control**
- ☐ **Nutrition Assistance Overpayment Compromise**

I want an appeal because I do not agree with: *(Check box)*

- ☐ **End of Benefits**
- ☐ **Amount of Benefits**
- ☐ **Denial of Application**
- ☐ **Overpayment**
- ☐ **Other *(Explain)*:**

Reason(s) why I don't agree with your decision:

Date of the Notice I do not agree with:

I want my hearing by: ☐ **Telephone**

☐ **In person at:** *(Select a location below):*

- ☐ **Phoenix**
- ☐ **Tucson**

NOTE: When an option is not selected, the hearing will be held by telephone.

I need an interpreter: ☐ **Yes** ☐ **No**
(If Yes, what language?)

I need an accommodation for a disability: ☐ Yes ☐ No

(If Yes, explain)

CONTINUED BENEFITS

IMPORTANT: You may keep getting benefits if you file an appeal within 10 days of the date of the notice you are disagreeing with or the effective date of the decision on the notice, whichever is later. Check one of the following boxes below if the reason for your appeal is because your benefits are being decreased or stopped.

☐ **I DO want to keep getting benefits during my appeal.**

☐ **I DO NOT want to keep getting benefits during my appeal.**

CAUTION:

If you ask to continue your benefits, you may have to pay back any Cash or Nutrition Assistance you received while waiting for a hearing.

You cannot keep getting benefits while you wait for a hearing if:

- **Your application was denied**
- **Your benefits were stopped because the approval period ended**
- **The law changed**
- **You received the maximum benefits under the program**

Name *(Print or Type)*:

_____

Signature: _____

Date: _____

YOUR APPEAL RIGHTS

DES must send you a letter when a decision is made on your case. An appeal is a request for a hearing. A hearing is your chance to explain your case to a judge who will decide if DES made the right decision.

You have the right to:

- **Appeal any decision we made that you do not agree with.**
- **Appeal a decision we do not make on time.**
- **Ask for a pre-hearing meeting with DES to discuss your case.**
- **Ask to review your DES case file by contacting an FAA office.**
- **Get a copy of the law, rule or policy that we used in your decision.**
- **Present testimony and evidence at the hearing to support your case.**

- **Bring a representative or lawyer to the hearing.**

What happens when you file an appeal?

- **We will send you a notice asking you to contact us for a pre-hearing meeting with DES. This meeting is to see if we may be able to fix the problem. This meeting is optional for you.**
- **If the problem cannot be fixed, the DES Office of appeals will send you a notice telling you the date and time of your hearing.**

What programs can you appeal?

Cash Assistance, Nutrition Assistance, Medical Assistance, and Tuberculosis Control.

How do you file an appeal?

- **Go online to your account at healthearizonaplus.gov**
- **Fill out this form and turn in the completed form by:**

Faxing:

The Appeals processing Unit (APU) at 602-257-7058 or

The Office of Appeals

Phoenix: 602-257-7056 or

Tucson: 602-257-7055

You can mail the form to:

Department of Economic Security – Appeals

PO Box 19009

Phoenix, AZ 85005-9009

- **Provide a written statement. This statement should include your name, case number or social security number, address, and phone number, the date of the letter you are appealing, and the reason you do not agree with the decision.**
- **To file a Verbal Appeal Request please call:**

The Appeals Processing Unit (APU): 602-774-9279 or

The Office of Appeals: 602-771-9019 or Toll Free 877-528-3330.

What is the deadline to ask for an appeal?

You must ask for an appeal within:

- **30 days from the date on the decision notice for: Cash Assistance and Tuberculosis Control.**
- **35 days from the date of the decision notice for Medical Assistance.**
- **90 days from the date on the decision notice for: Nutrition Assistance.**

Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact the Family Assistance Administration ; TTY/ TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local