DHS-121
Rev. 12-15

RHODE ISLAND
EXECUTIVE OFFICE HEALTH AND HUMAN SERVICES

REQUEST FOR A HEARING

SECTION I. IDENTIFYING INFORMATION- Please print.		
Name:	First 5 Digits of SSN:	
Street Address:	City/Town:	Zip Code:
Do you need an interpreter:	If so, what language:	

SECTION II. STATEMENT OF COMPLAINT (To be completed by applicant or recipient)
My appeal is about: ☐ RIW ☐ SNAP ☐ MEDICAID ☐ CHILD CARE ☐ HEALTHSOURCE RI ☐ MEDICAID DISABILITY ☐ GPA ☐ PROGRAM INTEGRITY ☐ LONG-TERM SERVICES AND SUPPORTS
Please explain the reason for your appeal:

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

Signature: _____ Date: _____
(Recipient)

SECTION III. STATEMENT OF AGENCY POLICY (To be completed by the Agency Representative)	
This appeal is about: ☐ RIW ☐ SNAP ☐ MEDICAID ☐ CHILD CARE ☐ HEALTHSOURCE RI ☐ MEDICAID DISABILITY ☐ GPA ☐ PROGRAM INTEGRITY ☐ LONG-TERM SERVICES AND SUPPORTS	
SPECIFIC ADMINISTRATIVE/LEGAL CITE:	Sections:
Explain agency decision in relation to policy and appeal:	

_____ _____
Agency Representative Signature Supervisor Signature

_____ _____
(Print Name) (Print Name)

Regional Manager _____ Local Office _____ _____

BRING AGENCY NOTICE TO HEARING