



OFFICE OF APPEAL HEARINGS HEARING REQUEST

I have been notified of the following action(s) taken regarding my public assistance benefits:

I am not satisfied with the action taken and request a hearing for the following reason(s):

I understand that my benefits, in some cases, may be continued at the level prior to this change. I also understand that if I have my benefits continued and the hearing decision upholds the agency's action, I am liable for the excess benefits received.

☐ I want my benefits continued at the previous level.

Name of person requesting hearing

☐ I do **NOT** want my benefits continued at the previous level.

Signature of person requesting hearing

Address

City

State

Zip

Date

Case Number / Social Security Number

This hearing request should be returned to the local Department of Children and Families office. If you wish to file directly, you may write to the Office of Public Assistance Appeal Hearings at 2415 North Monroe Street, Suite I, Room 129, Tallahassee, Florida 32303-4190, or call (850) 488-1429.

AGENCY USE ONLY

Type of benefit appealed: _____ Case#/Cat./Seq.: _____

Date supervisory review was held: _____ District/Office: _____

Additional agency action:

☐ The pertinent Notice of Case Action is attached.