Department of HUMAN SERVICES

Appeal and Request for Hearing

Who is Appeal For?

First Name	Middle Initial	Last Name	
Mailing Address			
City	State	Zip Code	Phone Number
Date of Birth	Address County		Case or Account Number, if known
Your Signature			Date

What Are You Appealing?

Check the programs you want to appeal:

☐ Adoption ☐ Adult Abuse ☐ Attribution of Resources ☐ Cash Assistance

☐ Child Abuse ☐ Child Care Assistance ☐ Child Support ☐ Food Assistance

☐ Foster Care ☐ Hawki ☐ Medicaid including waivers ☐ PROMISE JOBS

☐ State Supplementary Assistance Other:_____

Tell us why you are appealing:

Do you want your benefits to continue during your appeal? ☐ Yes ☐ No
(You may have to pay them back, if you lose your appeal.)

Do you want an informal conference with your worker? ☐ Yes ☐ No

Do you need help with your appeal because you are blind or hard of hearing? ☐ Yes ☐ No

Do you want a language interpreter for your hearing? ☐ Yes ☐ No

If yes, what language?_____

If someone will be helping you with your appeal, write that person's name and address below. **You do not have to list someone here. (If you are appealing child abuse or adult abuse, then only an attorney can help with your appeal.)**

Name			Phone Number
Mailing Address	City	State	Zip Code

Please mail, fax or email your appeal to:

Department of Human Services, Appeals Section 5th Floor, Des Moines, Iowa 50319-0114
Fax: (515) 564-4044 Email: appeals@dhs.state.ia.us