

IM-87 Instructions**APPLICATION FOR STATE HEARING**

PURPOSE: To provide a method of applying for a state administrative hearing. This form is to be used by the applicant, recipient, or their representative who is dissatisfied with an action proposed, taken, or not taken on the following programs:

- 1619
- Breast and Cervical Cancer Treatment (BCCT);
- Blind Pension (BP);
- Child Care (CC);
- Child Care Provider (CCP);
- Low Income Home Energy Assistance Program (LIHEAP);
- Emergency Medical for Ineligible Aliens (EMCIA);
- Extended Women's Health Services (EWHS);
- Food Stamps (FS);
- MO HealthNet for Aged, Blind, and Disabled (MHABD);
- MO HealthNet for Aged, Blind, and Disabled - Vendor (MHABD-VEN);
- MO HealthNet for Children in Care (MHCC);
- MO HealthNet for Disabled Child (MHDC);
- MO HealthNet for Families (MHF);
- MO HealthNet for Kids (MHK);
- MOCDD (Sara Lopez Waiver);
- MO HealthNet for Pregnant Women (MPW);
- Presumptive Eligibility (PE);
- Qualified Disabled Working Individuals (QDWI);
- Qualified Medicare Beneficiary (QMB);
- Specified Low-Income Medicare Beneficiaries (SLMB);
- Supplemental Nursing Care (SNC);
- Supplemental Payment (SP);
- Supplemental Security Income (SSI);
- Supplemental Security Income - Supplemental Payment (SSI-SP);
- Supplemental Aid to the Blind (SUPP AB);
- Temporary Assistance (TEMP ASSIST);
- Ticket to Work Health Assurance Program (TWHC); and
- Uninsured Women's Health Services (UWHS).

NUMBER OF COPIES AND DISPOSITION: This form may be completed by the applicant/participant, their representative, or by FSD personnel on behalf of the claimant/representative. The person requesting the hearing is referred to as the "claimant".

- Original - The IM-87 and the Action Notice (if available) are scanned to a file and e-mailed to the Administrative Hearing Unit (AHU) Regional Office. The original, completed IM-87 is retained in the claimant's case file.

The scanned file must be e-mailed to the AHU that serves the claimant's residence county as soon as possible, but no later than the close of business on the next working day following receipt of the hearing request. This timeframe applies to all program lines.

Refer to Income Maintenance memorandum [IM-114 Regional Administrative Hearings Units Change in](#)

[Assignments](#) dated December 31, 2012 to determine the AHU that serves the claimant's residence county. The e-mail addresses for the AHU offices are:

- Jefferson City regional office – DLS.JCIMHRG@dss.mo.gov
- Kansas City regional office – DLS.KCIMHRG@dss.mo.gov
- St. Louis regional office – DLS.STLIMHRG@dss.mo.gov
- Copy -
 - If the Division of Workforce Development (DWD) or the Missouri Work Assistance (MWA) providers have reported non-compliance with a program requirement that the claimant is appealing complete the steps listed below.
 - For Food Stamp hearings, on the same day that the IM-87 is submitted to the AHU, fax a copy of the original IM-87 to the DWD Administration Office at (573) 751-9528, Attention: Sanction Hearing Request.
 - For Temporary Assistance hearings, on the same day that the IM-87 is submitted to the AHU, fax a copy of the original IM-87 to the MWA provider that services your county.
 - For hearings on spend down incurred medical expenses scan the IM-87 and information about the hearing request such as the Notification of Spenddown Coverage (IM-29 SPDN) form to a file and e-mail as an attachment to the:
 - Appropriate regional SDU manager and supervisor. The subject line of the email must be HEARING REQUEST, case name, and DCN.
 - MHN Program and Policy Unit at [SPEND DOWN, MHN](#). The subject line of the email must be HEARING REQUEST, case name, and DCN.
 - For hearings related to Medical Review Team (MRT) disability determinations from the Springfield MRT, on the same day the IM-87 is submitted to the AHU, email a copy of the scanned IM-87 to [Processing Center, MRT](#). They will provide copies of medical records for the hearing.

MANUAL REFERENCE: Chapter X

INSTRUCTIONS FOR COMPLETION: FSD staff completes the gray areas of the form and the white areas are completed by the claimant, the claimant's representative, or by FSD staff based on the claimant's statements.

TOP GRAY AREA - COMPLETED BY AGENCY Print or type in the following information:

CATEGORY BEING APPEALED: Print or type in the following information:

1. CATEGORY BEING APPEALED: Enter a check in the box for the category or categories of assistance for which the application for a hearing is being filed.

2. DWD/METP (*Only applies to FS cases*): Check either yes or no if the hearing request is due to a sanction that resulted from a recommendation by the Division of Workforce Development (DWD) If yes, complete Sanctioned Individual, and SSN of Sanctioned Individual. **DO NOT check the DWD box for hearings on ABAWD issues.**

2 aMWA (*Only applies to Temporary Assistance cases*): Check either yes or no if the hearing request is due to a sanction that resulted from a recommendation by the Missouri Work Assistance (MWA) providers. If yes, complete Sanctioned Individual and SSN of Sanctioned Individual.

3. SANCTIONED INDIVIDUAL (for DWD/MWA hearing): List the name of the individual who is sanctioned or is proposed to be sanctioned. This individual may not be the head of the household for the assistance program. DWD and MWA staff utilize this field to identify the individual who is sanctioned or is proposed to be sanctioned.

4. SSN OF SANCTIONED INDIVIDUAL (for DWD/MWA hearing): Enter the Social Security Number of the individual who is sanctioned or is proposed to be sanctioned.

5. CASE NAME: Enter the name of the head of the household receiving the assistance for which the hearing is requested.

6. CASE DCN: Enter the Departmental Client Number (DCN) of the head of the household receiving the assistance for which the hearing is requested.

7. CASE RESIDENCE COUNTY: Enter the county of residence (where the applicant or participant lives.)

- The AHU uses this field to identify which AHU office will conduct the hearing.
- Administrative hearings are scheduled in the claimant's county of residence.

8. FSD OFFICE OF ACTION: Enter the name of the office that processed the case action.

- The AHU uses this field to identify where to send the notice of the scheduled hearing and where to call on the date/time of the hearing.
- If county has multiple offices, identify which office is involved.
- For offices that have reorganized and the office in the claimant's county of residence is a DSS Resource Center, enter the Customer Service Center's information.
- For offices doing work share, enter the office of the eligibility specialist (ES) that took the action, or the ES or ES supervisor (ESS) that will be representing the agency and presenting evidence from the applicant's/participant's official record.

NOTE: The FSD is still responsible to call the AHU to inform them when the claimant is available for the hearing.

9. CLAIMANT IS APPEALING: Enter a check to indicate the type of action being appealed. If "other" is marked, enter the action being appealed in the **REASON FOR PLANNED ACTION OR DECISION BY AGENCY** field.

10. DATE OF ACTION NOTICE FOR WHICH HEARING IS REQUESTED: Enter the date of the action being appealed, if applicable. There will not be an action notice for some cases; such as case delay or lack of opportunity to apply for benefits/services.

In FAMIS, action notices include, but are not limited to, one (or more) of the following:

- CD-150 CD Child Care Action Notice
- FA-150 Claimant Action Notice
- FA-410 Medicaid Adverse Action Notice
- FA-411 Medicaid Pre-Closing Notice
- FA-420 Adult MO HealthNet Adverse Action Notice
- FA-450 Medicaid Action Notice
- FA-510 Adverse Action Notice

11. DATE HEARING REQUESTED: Enter the date the claimant has said in person or over the phone s/he wishes to request a hearing. It is also the date on which the agency receives a request in writing by mail, fax, e-mail, or dropped off.

NOTE: If the hearing request is received more than 90 days after the date of action notice write on the top of the form "Over 90 days" prior to submitting to the AHU.

12. NAME AND DCN OF PERSON THE HEARING IS ABOUT OR FOR: Enter the name of the individual directly related to the reason for the hearing if it is different than the case name.

EXAMPLE: Bob and Helen Smith have an active MHABD non-spend down case. The case is in Bob's name. MRT has determined that Helen is no longer considered disabled. Bob has requested a hearing, but the hearing is about Helen's disability determination. Enter Helen's name in field 12.

13. REASON FOR PLANNED ACTION OR DECISION BY AGENCY: Enter a brief statement of the proposed action or the action already taken by the FSD and the basis for this action.

WHITE AREA - COMPLETED BY THE CLAIMANT

If the claimant requests the hearing in person, s/he or his/her representative completes this section of the form, if they are able to do so. FSD staff may also complete this section of the form by entering the claimant's or representative's statements.

If the hearing request is received by fax or mail, submit a copy of the claimant's written request with the scanned copy of the IM-87 that is e-mailed to the Administrative Hearing Unit.

14. NAME OF THE PERSON REQUESTING THIS HEARING: This may be the head of household, a household member, or an authorized representative. Enter the individual's first name, middle name or initial and last name.

15. TELEPHONE NUMBER: Enter the claimant's telephone number.

16. HOUSEHOLD MAILING ADDRESS: Enter the claimant's complete mailing address.

17. STATE PLAINLY THE REASON YOU ARE REQUESTING A HEARING: Enter the claimant's or representative's statement as to why s/he wants a hearing. If the request is received by fax or mail, submit a copy of the written request with the scanned copy of the IM-87 that is e-mailed to the Administrative Hearing Unit.

18. FOOD STAMP, TEMPORARY ASSISTANCE, AND/OR MO HEALTHNET RECIPIENTS: Explain this section to the claimant or representative. If the claimant has requested a hearing prior to the expiration of the adverse action notice, s/he chooses whether or not to continue to receive benefits at the level before the appealed action, while the hearing is pending.

19 and 20. FOOD STAMP, TEMPORARY ASSISTANCE, AND/OR MO HEALTHNET RECIPIENTS: Enter a check in the appropriate box. Based on the participant's response to the explanation provided in 18.

21. CLAIMANT'S REPRESENTATIVE - NAME: If applicable, enter the name of the claimant's representative or attorney.

22. REPRESENTATIVE TELEPHONE NUMBER: If applicable, enter the telephone number of the claimant's representative.

23. CLAIMANT'S REPRESENTATIVE - ADDRESS: If applicable, enter the complete address of the claimant's representative.

24. CLAIMANT'S SIGNATURE (OR SIGNATURE OF CLAIMANT'S REPRESENTATIVE): The claimant or his/her representative signs the form. If the claimant or his/her representative is not present, FSD staff should enter notations such as: "Claimant requested hearing by phone (or mail, fax, etc.). The Hearing Officer may request that the claimant or his/her representative sign the form at the hearing.

25. DATE: Enter the date the claimant or his/her representative or a FSD staff member completes the IM-87.

BOTTOM GRAY AREA - COMPLETED BY AGENCY

26. ELIGIBILITY SPECIALIST SCHEDULE & SCHEDULED TIME OFF: Enter the normal daily work schedule and any upcoming scheduled time off for the FSD ES or ESS who will be serving as agency witness for this hearing request. The AHU uses the information contained in this portion of the IM-87 to try to accommodate the FSD office schedule when determining the date for a hearing. Whenever the AHU schedule allows for honoring days off they will do so. The FSD office must make arrangements to have another ES or ESS act as agency representative if an ES or ESS has a hearing scheduled when they are absent.

27. DATE HEARING REQUEST SUBMITTED TO HEARINGS UNIT: Enter the date the IM-87 is scanned to a file and e-mailed to the Administrative Hearing Unit.

28. DATE EXHIBITS OR FOLLOW-UP DOCUMENTS MAILED TO HEARINGS UNIT: Enter the date that exhibits/follow-up documents are mailed to the Administrative Hearing Unit.

29. SIGNATURE OF ELIGIBILITY SPECIALIST: The ES that completed the form signs the form.

30. SIGNATURE OF SUPERVISOR: The ESS must review the case record to determine if the case action is correct or if the FSD should rescind the action or withdraw from the hearing. The ESS must schedule a pre-hearing conference with the claimant or their representative, if this has not already been completed

Review the information entered on the form to ensure that all appropriate areas of the form are completed correctly, and sign the form.

31. ES OR ESS WILL BE PARTICIPATING FROM ____ FSD OFFICE: Enter the office the AHU must contact on the date/time of the scheduled hearing to reach the FSD agency representative.

32. CLAIMANT WILL BE PARTICIPATING FROM ____ FSD OFFICE: Enter the office the AHU must contact on the date/time of the scheduled hearing to reach the claimant.

NOTE: The FSD is still responsible to call the AHU to inform them when the claimant is available for the hearing.

33. DATE IM-87 RECEIVED BY HEARINGS UNIT: The AHU completes this section with the date the form is received.

Revised, January 2013