



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 FAMILY SUPPORT DIVISION
APPLICATION FOR STATE HEARING

1. CATEGORY BEING APPEALED						
<input type="checkbox"/> BCCT	<input type="checkbox"/> EA	<input type="checkbox"/> MA	<input type="checkbox"/> MA-VEN	<input type="checkbox"/> PE	<input type="checkbox"/> SNC	<input type="checkbox"/> SUPP AB
<input type="checkbox"/> BP	<input type="checkbox"/> EMCIA	<input type="checkbox"/> MACC	<input type="checkbox"/> MAWD	<input type="checkbox"/> QDWI	<input type="checkbox"/> SP	<input type="checkbox"/> TEMP ASSIST
<input type="checkbox"/> CC	<input type="checkbox"/> FS	<input type="checkbox"/> MADC	<input type="checkbox"/> MC+	<input type="checkbox"/> QMB	<input type="checkbox"/> SSI	<input type="checkbox"/>
<input type="checkbox"/> CCP	<input type="checkbox"/> GR	<input type="checkbox"/> MAF	<input type="checkbox"/> MPW	<input type="checkbox"/> SLMB	<input type="checkbox"/> SSI-SP	<input type="checkbox"/>
2. DWD <input type="checkbox"/> YES <input type="checkbox"/> NO		3. SANCTIONED INDIVIDUAL			4. SSN	
5. NAME				6. TELEPHONE NUMBER		
7. MAILING ADDRESS (STREET, RURAL ROUTE, OR PO BOX, CITY, STATE, ZIP CODE)						
STATE OF MISSOURI, I hereby make application for a hearing provided by state law or department regulations.						
8. STATE PLAINLY THE REASON FOR THE HEARING REQUEST						
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9. FOOD STAMP AND INCOME MAINTENANCE (IM) (CASH/HEALTHCARE) RECIPIENTS:						
<p>If you are still certified for food stamps or are receiving Income Maintenance (cash/healthcare), you may choose to continue receiving benefits while your hearing is pending. If the hearing decision shows that the plan to reduce your benefits or close your case was correct, you or your household will be responsible for repaying the amount of benefits you received and were not entitled to receive while your hearing was pending. If you elect to discontinue receiving benefits while your hearing is pending and the hearing decision is ruled in your favor, these lost benefits will be restored to you.</p>						
<p>If you are requesting a food stamp hearing, check one of these boxes:</p> <p><input type="checkbox"/> I wish to continue receiving food stamps while my hearing is pending.</p> <p><input type="checkbox"/> I do not wish to continue receiving food stamps while my hearing is pending.</p>			<p>If you are requesting a Temporary Assistance and/or Medical Assistance hearing, check one of these boxes:</p> <p><input type="checkbox"/> I wish to continue receiving Temporary Assistance and/or Medical Assistance while my hearing is pending.</p> <p><input type="checkbox"/> I do not wish to continue receiving Temporary Assistance and/or Medical Assistance while my hearing is pending.</p>			
10. CLAIMANT'S REPRESENTATIVE: NAME					11. TELEPHONE NO.	
12. ADDRESS						
13. CLAIMANT'S SIGNATURE					14. DATE	
15. CASE DCN		16. SUPERCASE NUMBER			17. COUNTY	
18. CLAIMANT IS APPEALING (CHECK ONE)				19. DATE OF NOTICE OR DECISION APPEALED FROM		
<input type="checkbox"/> REJECTION <input type="checkbox"/> AMOUNT GRANT/ISSUANCE <input type="checkbox"/> CLOSING <input type="checkbox"/> DELAY <input type="checkbox"/> OTHER						
20. REASON FOR PLANNED ACTION OR DECISION BY AGENCY						
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21. DATE HEARING REQUESTED		22. DATE FOOD STAMP HEARING REQUEST FAXED TO HEARINGS UNIT		23. FOLLOW-UP DOCUMENTS FOR HEARINGS UNIT? <input type="checkbox"/> YES <input type="checkbox"/> NO		24. DATE FOLLOW-UP DOCUMENTS MAILED TO HEARINGS UNIT
25. SIGNATURE OF CASEWORKER				26. SIGNATURE OF SUPERVISOR		
27. IM-87 RECEIVED BY				28. DATE IM-87 RECEIVED		