

I understand that I may continue to receive my current level of assistance pending my appeal decision, if my appeal is filed within ten (10) day of my notice of adverse action. I also understand that the benefits must be repaid from future assistance or reimbursed to the Department of Health and Human Services directly, if the appeal decision is not in my favor.

If you do not wish to continue your assistance pending the appeal decision, please indicate in the box.
☐ Having checked this box, I understand that my assistance will be discontinued or reduced until an appeal decision is made.
Note: If the box is not checked, current level of benefits will continue.

Therefore, I appeal to the Director of Health and Human Services for review of this matter, and a hearing, if necessary, in accordance with the law.

(Signature of Applicant)

(Date)

(Street Address or P.O. Box Number)

(City, State, Zip)

(Telephone Number)

INSTRUCTIONS FOR COMPLETING REQUEST FOR FAIR HEARING

HEADING

Local Office –Enter the name of the local office of the applicant's (recipient's) residence and the case number in the appropriate places. Enter the date the Notice and Petition is received in the local office.

BODY OF FORM

1. Action or Inaction—Enter one of the following phrases: “Approving the application,” “Rejecting the application,” “Increasing the payment,” “Decreasing the payment,” “Discontinuing payment,” “Failing to act with reasonable promptness.”
2. Name and Address— Enter the name and address of the applicant (recipient).
3. Type of Aid—Enter the type of assistance: Aged to the Aged, Blind or Disabled (AABD), Aid to Dependent Children (ADC), Children and Family Services (CFS), Medical Assistance (MA), Food Stamp Program (FSP), Commodity Distribution (CD), Medically Handicapped Children (MHC), Emergency Assistance (EA), Low Income Energy Assistance Program (LIEAP), Refugee Resettlement Program (RRP).
4. Name – Give the name of the person appealing the action, (who may be the applicant, recipient, guardian, conservator, applicant's representative, or a taxpayer.)
5. Date—Enter the effective date (first of month for which action is effective) of the decision of the local office or other official from which the petitioner is appealing. If “failure to act with reasonable promptness” is the reason for the appeal, check (☐) appropriate box.
6. The Reason for Appeal –Write the specific reason for appealing from the decision of the local office or other official.

SIGNATURES AND DATES

The person making the appeal must sign the form, entering the date and his address.

PROCEDURES FOR A FAIR HEARING

1. This form should be completed in triplicate. Request for a fair hearing may also be made in the form of a simple letter or written request to the Legal Services - Hearing Section, P.O. Box 98914, Lincoln, Nebraska 68509-8914. The request must be made in writing.
2. If request is made on this Form (DA-6,) one copy is sent to the Nebraska Department of Health and Human Services, Legal Services- Hearing Section, one copy to the appropriate local office, and the third copy is retained by the person appealing.
3. The person appealing is notified by the Director or his/her representative of the date and place of hearing.
4. The hearing is held by the Director or his/her representative. Both the person appealing and the State may ask witnesses to appear.
5. A complete report of this hearing is made to the Director of the Nebraska Department of Health and Human Services by the Hearing Officer.
6. A written decision by the Director of the Nebraska Department of Health and Human Services is transmitted to both the person appealing and the appropriate local office.