



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

<b>CATEGORY BEING APPEALED</b>					
<input type="checkbox"/> BCCT	<input type="checkbox"/> EA	<input type="checkbox"/> MACC	<input type="checkbox"/> MC+	<input type="checkbox"/> QMB	<input type="checkbox"/> SSI
<input type="checkbox"/> BP	<input type="checkbox"/> EMCIA	<input type="checkbox"/> MADC	<input type="checkbox"/> MPW	<input type="checkbox"/> SLMB	<input type="checkbox"/> SSI-SP
<input type="checkbox"/> CC	<input type="checkbox"/> FS	<input type="checkbox"/> MAF	<input type="checkbox"/> PE	<input type="checkbox"/> SNC	<input type="checkbox"/> SUPP AB
<input type="checkbox"/> CCP	<input type="checkbox"/> MA	<input type="checkbox"/> MA-VEN	<input type="checkbox"/> QDWI	<input type="checkbox"/> SP	<input type="checkbox"/> TEMP ASSIST
<b>DWD</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		SANCTIONED INDIVIDUAL (FOR DWD HEARING)		SSN OF SANCTIONED INDIVIDUAL (FOR DWD HEARING)	
CASE NAME		CASE DCN	SUPERCASE NUMBER	COUNTY	
<b>CLAIMANT IS APPEALING (CHECK ONE)</b>		<b>DATE OF ACTION NOTICE FOR WHICH HEARING IS REQUESTED</b>		<b>DATE HEARING REQUESTED</b>	
<input type="checkbox"/> REJECTION	<input type="checkbox"/> AMOUNT GRANT/ISSUANCE				
<input type="checkbox"/> CLOSING	<input type="checkbox"/> DELAY <input type="checkbox"/> OTHER				
<b>REASON FOR PLANNED ACTION OR DECISION BY AGENCY</b>					
1. NAME OF PERSON REQUESTING HEARING		2. CASE NAME		3. CASE DCN	4. TELEPHONE NUMBER
				-	-
5. EU MAILING ADDRESS (STREET, RURAL ROUTE, OR P O BOX, CITY, STATE, ZIP CODE)					
STATE OF MISSOURI, I hereby make application for a hearing provided by state law or department regulations.					
6. STATE PLAINLY THE REASON FOR THE HEARING REQUEST					
<b>7. FOOD STAMP AND INCOME MAINTENANCE (IM) (CASH/HEALTHCARE) RECIPIENTS</b>					
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.					
If you are requesting a food stamp hearing, check one of these boxes:			If you are requesting a Temporary Assistance and/or Medical Assistance hearing, check one of these boxes:		
<input type="checkbox"/> I wish to continue receiving food stamps while my hearing is pending.			<input type="checkbox"/> I wish to continue receiving Temporary Assistance and/or Medical Assistance while my hearing is pending.		
<input type="checkbox"/> I do not wish to continue receiving food stamps while my hearing is pending.			<input type="checkbox"/> I do not wish to continue receiving Temporary Assistance and/or Medical Assistance while my hearing is pending.		
8. CLAIMANT'S REPRESENTATIVE: NAME				9. TELEPHONE NUMBER	
				-	
10. ADDRESS					
11. CLAIMANT'S SIGNATURE				12. DATE	
DATE <b>FOOD STAMP</b> HEARING REQUEST FAXED TO HEARINGS UNIT		DATE HEARING REQUEST MAILED TO HEARINGS UNIT		FOLLOW-UP DOCUMENTS FOR HEARINGS UNIT? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE FOLLOW UP DOCUMENTS MAILED
SIGNATURE OF ELIGIBILITY SPECIALIST		DATE IM-87 RECEIVED BY HEARINGS UNIT			
Nancy E. Young					
SIGNATURE OF SUPERVISOR					