DIVISION OF HEARINGS AND APPEALS
DHA-28 (08/09)

STATE OF WISCONSIN

REQUEST FOR FAIR HEARING

NAME		PHONE NUMBER	*SOCIAL SECURITY NO.
MAILING ADDRESS (Street, Apt. #, RFD, etc)			*CARES NO.
CITY	ZIP CODE	COUNTY OR AGENCY	CASE WORKER OR W-2 WORKER

EFFECTIVE DATE OF ADVERSE ACTION

⇐ **DATE YOUR BENEFITS WILL CHANGE**

If the action affects your MA or FoodShare benefits and your request is received before the effective date, your benefits in most cases, will not stop or be reduced. (Overpayment of benefits may be recovered by the county agency.) Do you wish your benefits to be continued? ☐ YES ☐ NO

✔ CHECK TYPE OF BENEFIT AND ACTION TAKEN THAT YOU ARE APPEALING

	APPLICATION DENIED	APPLICATION PROCESS DELAYED	TERMINATED (BENEFITS ENDING)	OVER-PAYMENT	BENEFIT AMOUNT REDUCED
☐ MEDICAL ASSISTANCE	☐	☐	☐	☐	☐
☐ LEVEL OF CARE (Nursing Home)					
☐ PRIOR AUTHORIZATION (What was denied? _____)					
☐ SSI-MA (State Supplement Cash Benefits)					
☐ FOODSHARE	☐	☐	☐	☐	☐
☐ NOT RECEIVED					
☐ DENIED 'EXPEDITED SERVICE'					
☐ MIGRANT HOUSEHOLD	☐	☐	☐	☐	☐
☐ ENERGY ASSISTANCE	☐	☐	☐	☐	☐
☐ FOSTER HOME RELATED (Name of Agency who took the Action: _____)					
☐ LICENSE DENIAL					
☐ LICENSE REVOCATION					
☐ REMOVAL OF CHILD					
☐ CARETAKER SUPPLEMENT	☐	☐	☐	☐	☐
☐ KINSHIP CARE	☐	☐	☐	☐	☐
☐ AFDC-Recovery of Past Benefits	☐	☐	☐	☐	☐
☐ CHILD CARE	☐	☐	☐	☐	☐

☐ W-2 – Fact-Finding Decision Review (Must have fact-finding review with W-2 agency before requesting this. Must include complete copy of fact-finding decision.)

Why are you asking for a hearing? (continue on other side if needed)

Signature (Specify if guardian, POA, etc.)	Date

*THE INFORMATION REQUESTED IS NEEDED TO IDENTIFY YOUR CASE AND PROCESS YOUR REQUEST. INCOMPLETE OR INACCURATE INFORMATION WILL DELAY THE PROCESSING OF YOUR REQUEST.

Return this completed form to: **DIVISION OF HEARINGS AND APPEALS, P.O. BOX 7875, MADISON, WI 53707-7875**