State of Illinois
Department of Human Services

STATEMENT OF FACTS

4(3 YEARS)

Date: _____

Case Number: _____

Office Name: _____

NAME: _____
ADDRESS: _____
ADDRESS: _____
CITY, ST. ZIP _____

Office Address: _____

Phone: _____

TTY: _____

Fax: _____

Tenemos este aviso en español. Para solicitar avisos en español, por Internet vaya al sitio ABE-MMC o llame al 1-800-843-6154, (TTY 1-866-324-5553 TTY/Nextalk, 711 TTY Relay).

You can manage your account online at abe.illinois.gov

Our review of your appeal and our records indicate you are appealing to the Department of Human Services for a hearing of the following issue(s):

BASIS OF APPEAL (Complete one or more as indicated)
PROGRAM: ☐ SNAP ☐ Medical ☐ AABD ☐ TANF ☐ Child Care ☐ RRA

1. Action/decision by: _____
By: (Bureau, Local Office, Section, etc.)

☐ Denial of application
Date of application: _____
Date Denial Notice Sent: _____

☐ Change in amount and/or manner of granting aid
☐ Reduction of benefits
☐ Discontinuation of case

☐ Filing of Lien on Real Property of Long Term Care Residents

Date notice of change was sent: _____
Effective date of change: _____
Overpayment Amount: _____
Other (explain): _____

☐ Amount of benefits
☐ Medical Spenddown Amount
☐ Allowance(s) and/or deductions from grant

Date of most recent eligibility determination: _____

Date action under appeal was taken: _____

FCRC Denial of Prior Approval Request or Decision Granting a Prior Approval Request for lesser or different Medical Service or Item. _____

2. Inaction by: _____
By: (Bureau, Local Office, Section, etc.)

☐ Application for: _____ , dated: _____

☐ Request for additional assistance, dated _____

3. Your initial request for a hearing was filed with the Department of Human Services on:
Written: _____ Oral to FCRC (SNAP only): _____
Telephone (1-800-435-0774): _____

CONTINUED ON REVERSE

State of Illinois
Department of Human Services

STATEMENT OF FACTS **4(3 YEARS)**

Date: _____

Case Number: _____

If mailed, your request was postmarked on: _____

The proposed action to reduce, suspend, or terminate your benefits (will/will not) be taken as your appeal (was/was not) filed on or before the date of change or within 10 days of the date of notice, whichever is later. If your cash and/or SNAP benefits are continued at the present level and the fair hearing decides the action to reduce/stop them was correct, you will have to pay back the excess benefits you receive. The amount of the excess benefits will be taken out of your future benefit payments. If your case is cancelled and you owe excess benefits, you must pay the Department for the excess benefits.

POSITION ON ISSUE(S) UNDER APPEAL:

1. Facts considered in arriving at position:

2. Policy or other citations supporting position: (Citations should be specific.)

FAMILY COMPOSITION

Enter the name, age and relationship to the grantee for all persons in the following sections.

1. At time of issue under appeal:
   A. Persons in Assistance Unit:
   B. Other persons in household:

2. For the current month:
   A. Persons in the Assistance Unit:
   B. Other persons in household:

CASH, MEDICAL, OR SNAP BENEFITS COMPUTATION: For each program being appealed, attach copies of the computation sheets completed for: 1. The time of issue now under appeal and 2. Current or proposed changes (indicate the effective dates on the copies of the computation sheets.)

(ADDITIONAL REMARKS SHOULD BE ATTACHED AS PART 0F THE FORM ON A SEPARATE PAGE.)

Date: _____ Signature: _____

_____
(Bureau, Local Office, Section, etc.)

NOTE: The Unit responsible for the action under appeal should send the original to the appellant as soon as the required review of the issue under appeal is completed so that the client receives it no less than 2 days prior to the hearing. Allow two (2) postal working days for receipt of the form by the appellant.

Prepare an Original and two (2) copies
SEND: Original to Appellant
1st copy to Case Record
Present 2nd copy to Hearing Officer at Hearing