



# REQUEST FOR HEARING

This information **must** be completed. (Please Print)

Customer Name: \_\_\_\_\_

Customer Date of Birth (Required): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone with area code: \_\_\_\_\_

My DRS counselor's name is: \_\_\_\_\_

If you need help in completing this form, please ask your Rehabilitation Counselor, HSP Representative, Rehabilitation Instructor, or Case Manager. If you need help requesting your appeal, or you would like to ask about possible representation, contact the Client Assistance Program, 100 South Grand Ave E., PO Box 19429, Springfield, IL. 62794-9429, 1-800-641-3929 (V/TTY).

**I am appealing a decision made by:**

- Vocational Rehabilitation (VR)
- Home Services Program (HSP)
- Bureau of Blind Services (BBS)

- I want to appeal a decision made by DRS on the following date: \_\_\_\_\_ .
- I want to appeal DRS' failure to respond to a request I made on the following date: \_\_\_\_\_ .
- I also want to request an informal resolution before the hearing, and understand it is my responsibility to contact my DRS representative or the office supervisor for scheduling.
- I am a VR or BBS customer and would like to request mediation before the hearing.

Briefly describe the decision(s) or lack of action you would like to appeal:



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## Check Only Those That Apply

- My disability is deafness or hard of hearing and I will need: **(Check One)**
  - Sign language interpreter
  - Tactile interpreter
  - Video - phone conference
  - CART services
- My disability is blindness or visual impairment and I will need: **(Check One)**
  - audiotape or disc
  - all materials provided in large print
  - all materials provided in Braille
  - a reader to assist in my preparation for the hearing
- My language preference is \_\_\_\_\_ rather than English. I will need an interpreter to participate in the hearing. **(Please fill in your normally spoken language.)**
- I am unable to attend the hearing in the local DHS-DRS office due to my disability. I am requesting to participate in the hearing by telephone.
- I have chosen to be represented by the following person or organization in this appeal: (PLEASE PRINT)

Name/Organization: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip Code: \_\_\_\_\_  
 Telephone with area code: \_\_\_\_\_ Alternate Telephone with area code: \_\_\_\_\_

**NOTE: If this form is not signed by the customer or by the designated representative, the request for hearing will be denied. If signed by the designated representative, attach the written authorization signed by the customer to request a hearing on behalf of the customer.**

■ **Sign your name or Make your mark** Customer: \_\_\_\_\_ Date: \_\_\_\_\_

■ **If you have made your mark (x) instead of signing your name, two witnesses must sign here**

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

■ \_\_\_\_\_ Relationship to customer  
 Representative or legal guardian of adult 18 years of age or older

■ **Parent or guardian signature is required if customer is 17 years of age or younger.**

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_ I am the parent or guardian of: \_\_\_\_\_

Please mail this form to the Bureau of Administrative Hearings, **with the notice you received**, if any, informing you of the decision you are appealing. You may send a copy of your appeal to the local field office listed below.

Illinois Department of Human Services  
 Bureau of Administrative Hearings  
 69 W. Washington, 4th Floor  
 Chicago, IL 60602

cc: Local Field Office