



STATEMENT OF FACTS 4(3 YEARS)

Date: _____

05c4ec31-f805-407f-bb83-8f58da50220b

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

Case Number: _____

Office Name: _____

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

