State of Illinois
Department of Human Services - Division of Family and Community Services

SENIOR FARMERS' MARKET NUTRITION PROGRAM (SFMNP) FAIR HEARING PROCEDURES

YOU HAVE THE RIGHT TO REQUEST A FAIR HEARING IF YOU ARE NOT SATISFIED WITH LOCAL AGENCY APPEAL PROCEEDINGS BECAUSE:

1. You have been denied entry into the Senior Farmers' Market Nutrition Program; or
2. You have been disqualified during a certification period; or
3. You have been terminated from the Senior Farmers' Market Nutrition Program and are not satisfied with the reasons given.

You have the right to a fair hearing before an impartial representative (hearing officer) of the local agency. If, after receipt of the decision of a hearing officer you are still not satisfied, then you have the right to request and receive a reconsideration of the decision by Illinois Department of Human Services. If the decision by the Department is not acceptable, then you have the right for a judicial review of Department's final decision.

HOW TO REQUEST A FAIR HEARING:

a. The fair hearing must be requested within sixty (60) days from the date the SFMNP issuing agency informs you (the applicant or participant) of termination or ineligibility, YOU MUST REQUEST A FAIR HEARING IN WRITING. The local SFMNP Issuing Agency must help you write the request if you ask for their assistance. A FAIR HEARING REQUEST FORM is available at the SFMNP benefit issuing agency.

b. The written FAIR HEARING REQUEST must be given to the local SFMNP benefit issuing agency.

c. You will be notified of the date, time and place of the hearing at least ten (10) days prior to the hearing date. The notice of the hearing will include an explanation of the hearing process.

d. At the hearing any positions or argument on your behalf may be presented personally or by a representative such as a relative, friend, legal counsel or other spokesperson.

e. The hearing shall be held within twenty-one (21) days and the decision of the fair hearing officer made within forty-five (45) days from the date the request for the hearing was received.

f. The decision of the hearing officer must be in writing and shall include at a minimum: a summary of the testimony (facts); the identity of the regulation; specific findings of fact (reasons for the decision); and the decision.

A REQUEST FOR A FAIR HEARING WILL BE DENIED IF:

1. You do not submit your written request within sixty (60) days as mentioned above; or
2. You, or your representative, withdraw your request in writing by submitting your withdrawal request to the local SFMNP benefit issuing agency; or
3. You, or your representative, fail without good cause to appear at the scheduled hearing; or
4. You have been denied participation by a previous hearing and cannot provide evidence that circumstances relevant to Program eligibility have changed to justify another hearing.

HOW TO APPEAL THE DECISION OF THE HEARING OFFICER:

a. If you are not satisfied with the decision of the Hearing Officer, you have fifteen (15) days from the date you received the notification to contact the local SFMNP benefit issuing agency in writing or in person that you want a reconsideration by the Illinois Department of Human Services.

b. The local SFMNP benefit issuing agency will forward the complete record of the hearing to the Illinois Department of Human Services within five (5) days of your reconsideration request.

c. The Illinois Department of Human Services will notify you on the results of the reconsideration within fifteen (15) days of the receipt of the record. If the local agency hearing record is incomplete or if deemed necessary to reach a fair decision, the Illinois Department of Human Services will arrange another hearing at the state level.

d. If you disagree with the reconsideration request or the State Hearing Officer's decision, a judicial review may be obtained pursuant to the Illinois Administrative Review Act, Illinois Revised Statue, Chapter 110, paragraph 264 et seq. You must file your complaint with the Illinois Department of Human Services within thirty-five (35) days from the date you receive a copy of the decision.

This Institution is an equal opportunity provider.

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FAIR HEARING REQUEST FORM

I, ______________________________
Appellant's Name

______________________________ ______________________ ____________
Address City/State Zip Code

____
Telephone Number

Hereby appeal to the ______________________________
Local SFMNP Certifying Agency

For a fair hearing because: (Please be as clear and specific as you can be in stating why you are requesting a fair hearing below).

______________________________ ______________
Appellant's Name Date

Submit this form to the SFMNP benefit issuing agency.

FOR AGENCY USE: To be completed by SFMNP agency

Date Fair Hearing Request Received: ______________________________

Date Hear Notice Sent: ______________________________

Date of Hearing and Decision: ______________________________

Date Decision Sent to Appellant: ______________________________

Date Appellant's Reconsideration Request Received: ______________________________

Date Hearing Record Sent to IDHS Farmers' Market Program: ______________________________

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