ARKANSAS DEPARTMENT OF HUMAN SERVICES

Request for Appeal Hearing

If you need this form in a different format such as large print, call your local DHS county office.

DHS Client Name: _____ Date of Birth: _____
DHS Client Address: County: _____
_____ Phone number: _____
_____ Alt. Phone number: _____
_____ Case Number: (if available) _____
Date of Action: (if known)_____ Email: _____

If completing this form on behalf of a DHS client, please provide your name, address, phone, and email below.

Requestor Name: _____ Phone number: _____
Requestor Address: Alt. Phone number: _____
_____
_____ Email: _____
_____

Answer the questions below to request a hearing to appeal an action taken by DHS about your benefits.

1. What action are you appealing? (Check all that apply)
   - ☐ I was not allowed to file an application.
   - ☐ I filed an application, but it has not been processed in a reasonable amount of time.
   - ☐ My application was denied.
   - ☐ I was getting benefits, but my case was closed.
   - ☐ The amount of my benefits is inadequate.
   - ☐ My benefits were reduced.
   - ☐ My cash assistance payment is being held. (Transitional Employment Assistance)
   - ☐ I disagree with charges on my Electronic Benefits Transaction (EBT) card balance.
   - ☐ I was not given freedom of choice in selecting which services I would get.
   - ☐ I am not satisfied with my foster care, adoption, supportive or child protective services.
   - ☐ I believe I have been discriminated against on the basis of: ☐age ☐race ☐color ☐sex ☐disability ☐religion ☐national origin ☐political beliefs.
   - ☐ Other: _____

2. In what program was this action taken? (Check all that apply)
   - ☐ Medicaid Assistance
   - ☐ SNAP Benefits (Supplemental Nutrition Assistance Program)
   - ☐ Cash Assistance (Transitional Employment Assistance, TEA)
   - ☐ Child Protective Services
   - ☐ Other: _____

You may elect to continue your SNAP, TEA, or Medicaid benefits between now and your appeal decision by checking one of the boxes to continue getting benefits below, however if you lose your appeal, you may have to repay the amount of benefits you received during that time. If you do not check any of the below boxes, DHS will assume you do not wish to continue your benefits pending your appeal hearing. (An additional comments section is on the second page to provide more information if needed.)

SNAP BENEFITS	TEA	MEDICAID
☐ I want to continue getting the amount of SNAP benefits I now receive until the hearing.	☐ I want to continue getting the amount of TEA I now receive until the hearing.	☐ I want to continue getting medical assistance until the hearing.
☐ I do not want to continue receiving the amount of SNAP benefits I now receive until the hearing.	☐ I do not want to continue receiving the amount of TEA I now receive until the hearing.	☐ I do not want to continue receiving medical assistance until the hearing.

_____ Signed_____ Date:_____
Witness, if signature is by mark

DHS-1200 (09/19)

If you are a DHS Client or his/her representative:

EMAIL TO: DHS.Appeals@dhs.arkansas.gov

OR

MAIL TO: Arkansas Department of Human Services
Appeals and Hearings Section
Slot N401
P.O. Box 1437
Little Rock, AR 72203-1437

If you are a DHS Provider or its representative:

MAIL TO: Arkansas Department of Health
Office of Provider Appeals
4815 West Markham Street, Slot 31
Little Rock, AR 72205-3867

Additional comments concerning your appeal:

DHS Client Instructions for DHS-1200

The DHS-1200 should be completed by the client or his/her representative. A county office representative, family service worker or other appropriate DHS staff will assist if requested to do so.

The client or his/her representative should complete all applicable fields and check the appropriate line(s) to indicate the reason(s) for a hearing request. If the DHS-1200 is signed by a mark, another person must also sign as a witness.

Please include a copy of the "Notice of Action" that you are appealing. If emailing the completed form, please also attach a scanned copy or picture of the "Notice of Action" that you are appealing to the email message.

DHS Staff Instructions for DHS-1200
(for Official Use Only)

The Completed DHS-1200 and a scanned copy or picture of the "Notice of Action" should be emailed by the County Office to the central Office Appeals and Hearings DHS.Appeals@dhs.arkansas.gov.