

**South Carolina Department of Social Services
REQUEST FOR FAIR HEARING**

A signed letter from the client requesting a fair hearing may be attached instead of this signed form.

To be completed by county worker or client:

Client's Name: _____	Case Number: _____
Client's Address: _____ _____ _____	County: _____ County Worker's Name: _____
Client's Telephone: _____	Program:
Client's Representative and Address: (If any) _____ _____ _____	<input type="checkbox"/> FI <input type="checkbox"/> JUMMP
	<input type="checkbox"/> Adoptions <input type="checkbox"/> SNAP
	<input type="checkbox"/> Child Protective Services <input type="checkbox"/> E&T
	<input type="checkbox"/> ABC <input type="checkbox"/> Licensing
	<input type="checkbox"/> Child and Adult Care Food Program <input type="checkbox"/> Foster Care
	<input type="checkbox"/> Other: _____
Notice Sent on: _____	When was the client notified of the action he/she
Effective Date: _____	wishes to appeal? _____

If you need any of the following accommodations, please ask for them. They will be furnished at no cost.

- Interpreter** **Documents Translated** **Special Accommodations**

What language? _____

What accommodations? _____

I request a fair hearing from the South Carolina Department of Social Services because:

- Action has not been taken on my application within a timely manner.
- My application has been turned down.
- My check/service has been stopped.
- My check/service has been reduced or changed.
- I have been charged with an overissuance or overpayment.
- My EBT account has been incorrectly adjusted due to a system error.
- Other: (Explain. Attach a sheet, if additional space is needed.) _____

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

You may also file a complaint of discrimination by contacting DSS. Write DSS Office of Civil Rights, P.O. Box 1520, Columbia, SC 29202-1520; or call 1-800-311-7220 or (803) 898-8080, TTY: 1-800-311-7219.

Federal law requires 10 days advance notice for a SNAP hearing; for other hearings, there is normally 30 days notice. You may request that your hearing be scheduled sooner. Please indicate the amount of advance notice you will need.

- 10 days 30 days ASAP Other: _____

If I am eligible to receive continued benefits or continued access to a disputed EBT amount:

- I wish to receive benefits if I am eligible, pending the hearing decision; however, I understand I must repay the continued benefits or disputed amount if the decision is not in my favor.
 I do not wish to receive continued benefits or continued access to a disputed EBT amount.

You may choose to have a telephone hearing, video conference hearing or a hearing by computer. If you do not choose, a telephone hearing will be scheduled.

- Telephone Hearing Telephone: () _____
 Computer Hearing
 Video Conference Where Available

The following people will testify in my case, and I will notify them of the time, date and place of the hearing:

The agency can issue subpoenas for you to require the attendance of a particular witness(es). However, by requesting a subpoena, you automatically accept responsibility for all charges associated with the subpoena, i.e., most professionals charge by the hour and for mileage. DSS does not accept any responsibility for witness fees in your case.

I accept the costs and I request that a subpoena be issued for the following people. I understand that I must give the hearing office a complete name and address for each witness.

Signature: _____ Date: _____

**Call the Office of Administrative Hearings if you have questions:
1-800-311-7220 or TTY 1-800-311-7219
Columbia area: (803) 898-8080**

**When complete, please return the form to your worker or mail to the:
Office of Individual and Provider Rights, P.O. Box 1520, Columbia, SC 29202-1520
or Fax to: (803) 898-7269**