ADMINISTRATIVE APPEAL AND HEARING REQUEST
State Form 53932 (R/2-12) / H&A 1001

*****THIS FORM MAY BE USED TO FILE A WRITTEN ADMINISTRATIVE APPEAL.*****
FOOD STAMP APPEALS MAY BE ALSO FILED VERBALLY BY CALLING 1-800-403-0864.

Name: _____________________________________________
Address: __________________________________________
Phone number: ______________________________________
Relationship: __________________________ (self, spouse, representative, relative)
Signature: ______________________ Date (month, day, year): ______________

Did you receive a written notice about the denial, termination or change of your benefits? ☐ YES ☐ NO

Mailing date of the notice (if known) ______________ Case number shown on the notice: _____

List of names of persons you are appealing for, including yourself:
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

What benefits are you appealing? Benefit was:
☐ TANF ☐ Denied ☐ Terminated / Closed ☐ Changed
☐ Medicaid ☐ Denied ☐ Terminated / Closed ☐ Changed
☐ HIP (Healthy Indiana Plan) ☐ Denied ☐ Terminated / Closed ☐ Changed
☐ Food Stamp ☐ Denied ☐ Terminated / Closed ☐ Changed
☐ Child Care (CCDF) ☐ Denied ☐ Terminated / Closed ☐ Changed
☐ Other - Explain ☐ Denied ☐ Terminated / Closed ☐ Changed

Mail or fax your request to the location listed below or you may deliver your request in person at the local Division of Family Resources office. If possible, please attach a copy of the notice you are appealing.

Mail or fax to: FSSA Document Center
PO Box 1810
Marion, Indiana 46952
Fax: 1-800-403-0864