DEPARTMENT OF CHILDERN AND FAMILIES

FAIR HEARING REQUEST

Department of Children and Families
Office of Appeal Hearings
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

Fax #850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us
Phone #850-488-1429

Dear DCF:

I would like to request a hearing before the Department of Children and Families because of action taken regarding my eligibility for or receipt of benefits.

Name: _____SSN: _____

Address: _____

Type of Benefit: _____ Case#: _____

Translator requested: ☐ Yes ☐ No LANGUAGE NEEDED:_____

Reason for hearing request:

I DO NOT AGREE WITH THE DEPARTMENT'S DECISION REGARDING MY CASE.

_____

_____

_____

_____

I understand that by appealing timely, my benefits will be continued at the level received prior to this change.

Signed:_____ Date:_____

My authorized representative is:

Name: _____

Address: _____

Phone Number: _____