Commonwealth Of Virginia
Department Of Social Services

To **Hearing and Legal Services Manager**
Virginia Department of Social Services
5600 Cox Road
Glen Allen, Virginia 23060

County/City
Case Number
Name
Address
City, State, Zip

Appeal to State Department of Social Services

My appeal is about the following program(s):

- ☐ Auxiliary Grants
- ☐ Child Care Subsidy Program
- ☐ Energy Assistance (limited to items with an asterisk "*")
- ☐ General Relief
- ☐ Percentage of Income Payment Program (PIPP)
- ☐ Refugee Cash Assistance
- ☐ Refugee Medical Assistance
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Other_____

To be valid/timely, SNAP appeals must be received within 90 days of written notice of the local agency decision. All other appeal requests must be received within 30 days of written notice of the local agency decision. All appeal requests must meet appropriate deadlines as required by law. There is no requirement that a request for an appeal for SNAP or TANF be made in writing. The request for an appeal for SNAP or TANF may be oral.

Attention:
I hereby request a review of the (proposed) action of the Department of Social Services in the County/City of _____ for the reason(s) checked below:

☐ Refusal to take my application for assistance or services*	☐ Refusal to take my application for SNAP benefits	☐ Declaring me ineligible for assistance or services*	☐ Declaring my household ineligible or declaring some household members ineligible for SNAP benefits
☐ Suspending my assistance or services	☐ Failure to provide expedited service on my SNAP case	☐ Canceling my assistance or services*	☐ Cancelling my SNAP benefits
☐ Failure to take action on my request for an increase in my assistance or services which was made on: _____ Date	☐ Decreasing my SNAP benefit amount	☐ Failure to render a decision on my application for assistance or SNAP benefits within the allowable time limit* My application was made on: _____ Date	
☐ Awarding me insufficient assistance of $_____	☐ Failure to adjust my PIPP Client Monthly Payment amount	☐ Decreasing my assistance from $_____ to: $_____ ☐ Decreasing my services _____ From_____ days/hours to _____ days/hours	

☐ Other (explain) _____

I believe I am eligible for assistance, services, or SNAP benefits or an increase in assistance or services or adjustment in SNAP benefits because:

_____

_____

I understand that any assistance and/or SNAP benefits received until a hearing decision is given must be repaid to the agency if the hearing decision supports the action being proposed by the agency.

I wish my SNAP benefits to continue until a hearing decision is rendered: ☐ Yes ☐ No

I wish my assistance or services to continue until a hearing decision is rendered: ☐ Yes ☐ No

I received a written notice from the Social Services Department on (date)	Name/Address/Telephone of Claimant's Legal Representative (if selected)
Claimant Signature	Date