APPENDIX H

City of Manchester N.H.
Welfare Department
1528 Elm Street, Manchester, NH 03110-1510
Phone: 603-624-6484 Fax: 603-624-6423
Email: welfare@manchesternh.gov

Fair Hearing Request

Date:_____ **Caseworker:**_____

Name:_____

Address:_____

Contact Phone Number:_____

I hereby request a Fair Hearing to appeal the adverse action on the Notice of Decision

dated _____

Reason for Fair Hearing Request:

In order to request a Fair Hearing, the client must complete and return this form to the City of Manchester N. H. Welfare Office within five (5) working days starting with the date of the Notice of Decision at issue. A Fair Hearing will be scheduled within seven (7) working days upon receipt of this request. The client will be notified in a timely manner of the place, date and time of the hearing.

IF YOU ARE CURRENTLY RECEIVING ASSISTANCE, COMPLETE THIS SECTION.
I __want __ do not want my current assistance to continue until my appeal has been decided. Continuance of my assistance is dependent upon keeping all scheduled appointments. I understand that if I lose my appeal, I will be obligated to repay the assistance provided to me by the City of Manchester during the time the appeal is being decided.

I have been given a copy of this Fair Hearing Request and a copy of the Fair Hearing procedures.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

Form 1007 1-2015