Commonwealth Of Virginia
Department Of Social Services

To Hearing and Legal Services Manager
Virginia Department of Social Services
801 East Main Street
Richmond, Virginia 23219-2901

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

Appeal To State Department Of Social Services

To be valid/timely, SNAP (food stamps) 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.

My appeal is in regard to the following program(s):

- ☐ Temporary Assistance For Needy Families (TANF)
- ☐ SNAP Benefits (Food Stamps)
- ☐ General Relief
- ☐ Auxiliary Grants
- ☐ Energy Assistance (limited to items with an asterisk "*")
- ☐ Services (e.g., Child Care)
- ☐ Refugee Cash Assistance
- ☐ Refugee Medical Assistance
- ☐ Other_____

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 to participate in the Supplemental Nutrition Assistance Program (SNAP)
☐ Suspending my assistance or services		☐ 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	☐ Failure to provide expedited service on my SNAP case	☐ Failure to render a decision on my application for assistance or SNAP benefits within the allowable time limit:* Application was made on: _____ Date	
☐ Awarding me insufficient assistance of $_____	☐ Decreasing my SNAP benefit 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