



THE NAVAJO NATION
DEPARTMENT FOR SELF RELIANCE
 DIVISION OF SOCIAL SERVICES

Request for Appeal Hearing

I am requesting an Appeal Hearing because I do not agree with the Decision

Notice dated ___ / ___ / ___ **to:**

- Deny** my Application for Department for Self Reliance (DSR) Assistance.
- Close** my case due to no longer meeting DSR eligibility requirements.
- Close** my case due to not cooperating with DSR Staff/Investigators.
- Disqualify** me and all members of my benefit group due to committing an Intentional Program Violation.
- Penalize** my case by reducing my monthly assistance amount.
- Decrease** my monthly assistance amount for a non-penalty reason.
- Decrease** my monthly assistance amount due to an overpayment.
- Not Pay** my next monthly assistance payment.

NOTE: ATTACH A COPY OF THE DECISION NOTICE

I do not agree with the decision because: (use the back for additional information)

CUSTOMER'S NAME	CIF NUMBER (if known)
MAILING ADDRESS	TELEPHONE NUMBER ()
E-MAIL ADDRESS	MESSAGE PHONE NUMBER ()
CUSTOMER'S SIGNATURE	DATE