State of Illinois
Department of Human Services

4 (3 YEARS)

IMPLEMENTATION OF APPEAL DECISION

TO: Bureau of Administrative Hearings

FROM: " Local Office Administrator " Other (specify) ____________________
Local Office____________________

RE: Client Name ____
Last *First*

Appeal No. ____________________ Case No. ____________________

The Department's Policy Manual (PM 01-07-12) requires that appeal decisions be implemented immediately, but no later than 10 days after the decision is received in the local office for Food Stamps and no later than 90 days after the date the appeal was filed for cash and medical benefits, unless the appellant asked for a delay. Complete this form to report implementation of appeal decisions which direct the Department to take additional action. Appeal decisions affirming all Department actions or dismissing the appeal for want of jurisdiction are not to be reported. No Form 1456 is required if the direction states only that an overpayment determination is not affirmed.
NOTE: Some appeal decisions contain two or more directions, one or more of which may require implementation.

Check (X) sections as appropriate.

Section I

○ **NO ACTION REQUIRED TO IMPLEMENT APPEAL DECISION.**
(If checked, skip to IMPLEMENTATION SUMMARY and complete)

Action to reduce/terminate assistance/benefits was reversed but assistance/benefits were continued at previous level pending the appeal decision. In such cases, the date of the appeal decision is both the date of implementation and the date the client was notified.

Section II

○ **ACTION REQUIRED TO IMPLEMENT APPEAL DECISION - NO ISSUE REGARDING BENEFIT LEVEL**

Decision on an issue not involving the level of benefits (such as a request for exemption from participation in particular activities) was reversed.

A) Action taken to implement decision

B) Date and method by which client was notified of implementation ____________________

Section III

○ **ACTION REQUIRED TO IMPLEMENT APPEAL DECISION - BENEFITS AFFECTED**

Action to deny/reduce/terminate assistance/benefits was reversed (including actions in which assistance/benefits were not continued pending the appeal decision).

A) Check (X) the action resulting from implementation of the appeal decision

☐ Assistance/benefits/services increased/authorized.

☐ Assistance/benefits/services terminated, reduced or denied.

☐ Monthly recoupment amount recalculated.

☐ Other: ____________________

B) Date and method by which client was notified of implementation ____________________

Section IV

◯ **ADJUSTMENT OF MEDICAL ASSISTANCE** (complete if applicable)

A) Medical Assistance backdated to ____________ Authorization date ____________

B) Ongoing Medical Assistance from __________ to ____________ Authorization date ____________

C) Service or item approved ____________________ Authorization date ____________

D) Service or item denied ______________________________ Authorization date ____________

Section V

◯ **ADJUSTMENT OF FINANCIAL ASSISTANCE** (complete if applicable)

A) Retroactive benefits from ______________ to______________ Authorization date __________

B) Ongoing benefits beginning ______________________________ Authorization date __________

C) Special issuance (purpose) ______________________________ Authorization date ____________

Section VI

◯ **ADJUSTMENT OF FOOD STAMP BENEFITS** (complete if applicable)

A) Retroactive benefits from ______________ to________________ Authorization date ___________

B) Ongoing benefits beginning __________________________________ Authorization date ___________

Section VII

◯ **CLIENT DELAYED IMPLEMENTATION OF APPEAL DECISION** (post hearing only)

Explain fully how the client caused the delay and the length of the delay. (Note: Ordinary processing time, including reasonable time to respond to a request for information, is not considered as client delay.)

IMPLEMENTATION SUMMARY

In table below, complete both boxes for each assistance program in which the Department was directed to take action. If Section I was checked above, enter the date of the Final Administrative Decision in the first box. If any other section was checked, enter either the date that notice of the implementation was sent to the client or, if eligible, the date that benefits or services were authorized, whichever is later. If there was no post hearing client delay, write "N/A" or "0" in the second box.

PROGRAM	DATE IMPLEMENTATION COMPLETED	POST HEARING CLIENT DELAY DAYS
AABD		
TANF		
Medical Assistance		
Food Stamps		
Other		

______________________________ ____________
Signature Date