OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Request for Review of Decision on Appeal by the Director of Department of Human Services

Director of Department of Human Services
C/o Appeals Unit, Legal Division
P.O. Box 53025
Oklahoma City, OK 73152

To be completed by the local office	
Case name	
Case number	Hearing number
Date of this request	

Dear Sir or Madam:

REQUEST

I hereby request that you review the Oklahoma Department of Human Services' decision made on my appeal for the following reasons:

I understand that for my request to be considered, my request must be made in writing within 30 days of the date of the decision letter on my appeal.

SIGNATURE

A. If the request for director review is made by the client, this item is completed.

Client's signature _____ Date _____

Witness if signed by mark:

Signature of first witness _____ Signature of second witness _____

Street address	City	State	Zip

B. If the request for the director review is being made by an authorized representative, this item is completed.

Signature of authorized representative _____ Date _____

Witness if signed by mark:

Signature of first witness _____ Signature of second witness _____

Street address	City	State	Zip