

HEARING SUMMARY

Customer Name: _____ **Customer ID #** _____

Customer Address: _____

OAH ID #: _____

Program (Please check appropriate program)

Temporary Cash Assistance (TCA) _____

Temporary Disability Assistance Program (TDAP) _____ Food Stamps _____

Medical Assistance _____ Maryland Children's Health Program _____

Other (specify) _____

Summary (Concise Details)

Basis for Decision:

COMAR :

Local Department Representative

Title

Date

August 2006