



North Carolina Department of Health and Human Services

Hearings and Appeals Section

2418 Mail Service Center • Raleigh, North Carolina 27699-2418

Tel 919-855-3260 • Fax 919-715-1910

REQUEST FOR STATE APPEAL

(To be completed by County DSS & submitted within 5 days of Appeal Request Date – Print legibly)

County: _____ DSS Address: _____
(Address of county office = location of hearing)
DSS Worker Name: _____ DSS Supervisor Name: _____
Phone # _____ Ext. _____ Phone # _____ Ext. _____
E-mail _____ E-mail _____

Date of Appeal Request: _____

Appellant: _____ SSN: _____
Address: _____ DOB: _____
City, State, Zip _____ Phone # _____
Alternate Phone # _____

Date of Application: _____ Sex: Male / Female

PDC (IMC) # or PI Claim # _____

Representative: Yes or No If Yes: Name of representative: _____
Title: (Attorney, Hospital worker, Relative, Friend, etc.) _____
Address: _____
Phone #: _____

Reasonable accommodations needed free of charge in order to participate in State hearing process:

- Interpreter, What language: _____
 Other accommodation, Explain: _____

Attach the following to this Request for State Appeal: (Check items attached.)

- Copy of DSS notification letter to grant, deny, terminate, or modify assistance that prompted appeal
(DMA 5024, 5059, 5102, 5119, etc., DSS 8108, 8109, 8110, 8551, 8553, 8556, 8558, 8586, 8587, 8588, 8632, 8639, 8642, etc.).
- Copy of local appeal hearing summary & decision, if applicable.
- Copy of D34037 Medicaid Disability Determination Transmittal from DDS, if appealing the medical decision by DDS and must include copies of all medical records returned from DDS.
- Copy of DMA-5135 and all related medical records, if applicable. (Appeal issue involves the medical decision made on an Emergency Medical Assistance claim.)
- Copy of relevant documents related to appeal (application/recertification/trial budgets/MRA/5097s/5013/ etc. & citation of the specific regulations that was the basis for the County's action).
- If PI, copy of completed DSS-1473A - Addendum for Program Integrity Food & Nutrition Services

Program: (Check one block. If appealing actions in multiple programs, then separate Appeal Request Forms must be prepared for each program.)

- | | |
|---|--|
| <input type="checkbox"/> MAA | <input type="checkbox"/> Adoption Assistance |
| <input type="checkbox"/> MAA–Emergency Ser.MID # _____ | <input type="checkbox"/> CAP/DA |
| <input type="checkbox"/> MAB | <input type="checkbox"/> CIP |
| <input type="checkbox"/> MAB–Emergency Ser.MID # _____ | <input type="checkbox"/> LIEAP |
| <input type="checkbox"/> MAD | <input type="checkbox"/> Day Care |
| <input type="checkbox"/> MAD–Disagrees <u>DDS</u> disability decision | <input type="checkbox"/> FNS |
| <input type="checkbox"/> MAD-- <u>Prisoner</u> –Disability (DMA Admin. Letter #09-08) | <input type="checkbox"/> FNS – SNAP (Simplified) |
| <input type="checkbox"/> MAD- Emergency Ser.MID # _____ | <input type="checkbox"/> FNS - Disaster |
| <input type="checkbox"/> MAF | <input type="checkbox"/> FNS-ADH (IPV Disqualification - PI) |
| <input type="checkbox"/> MAF–Emergency Ser.MID # _____ | <input type="checkbox"/> FNS-IPV Overissuance (PI) |
| <input type="checkbox"/> MIC | <input type="checkbox"/> FNS-IHE Overissuance (PI) |
| <input type="checkbox"/> MIC–Emergency Ser.MID # _____ | <input type="checkbox"/> FNS-AE Overissuance (PI) |
| <input type="checkbox"/> MPW | <input type="checkbox"/> SA |
| <input type="checkbox"/> MPW–Emergency Ser.MID # _____ | <input type="checkbox"/> SAA |
| <input type="checkbox"/> MQB | <input type="checkbox"/> SAD |
| <input type="checkbox"/> Medicaid Transportation | <input type="checkbox"/> Work First |
| <input type="checkbox"/> NCHC | <input type="checkbox"/> Work First Program Integrity |
| <input type="checkbox"/> HCWD | <input type="checkbox"/> Other: _____ |

Appealable Issue for State Hearing: (Check one block. If appealing multiple actions, then separate 1473s must be prepared)

- Application denied – DSS Reason:

- Denied for failing to timely provide information – DSS Reason (*what was needed*):

- Benefits/Services terminated – DSS Reason:

- Benefits/Services reduced/modified/changed – DSS Reason:

- Charged an overissuance – DSS Reason:

- Administrative Disqualification – DSS Reason:

- Other (*Explain*):

If applicable, Continuation of Benefits requested: Yes or No