

**NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES**

REQUEST FOR STATE APPEAL

Appellant: _____ County: _____

Address: _____ Program: _____

_____ Soc.Sec.#: _____

City, St.,Zip: _____ Case #: _____

Date of Request: _____

Date of Application: _____ Date of Birth: _____ Phone #: _____

Reason for request: (Identify county action, issue, and date of notice) _____

Date of local appeal: Request: _____, Hearing: _____, Decision: _____

Number of days due to client delay during local appeal: _____

Is client assisted by legal counsel or other representative? _____ If so, state name and address:

PLEASE ATTACH A COPY OF THE FOLLOWING: 1. Local appeal hearing decision, 2. Medicals and Social History for cases involving a disability or incapacity, 3. Most recent Medicaid/DDS denial,if applicable.

Worker _____ Director _____

Supervisor _____ Date _____

Submit to:

Copies to:

Chief, Hearings and Appeals Section
NC Department of Health and Human Services
Division of Social Services
325 N. Salisbury Street
2418 Mail Service Center
Raleigh, N.C. 27699-2418

Appellant
County Department of Social Services