

**NORTH CAROLINA
NOTICE OF DECISION
OF LOCAL APPEAL HEARING**

Date _____

Name: _____

Program: _____

Case Number: _____

Dear _____:

On _____, you and your representatives testified at a hearing to decide whether the county's decision relating to your assistance was correct. The hearing was held because:

(State the client's claim)

The county indicated:

(Summarize county's evidence.)

You indicated:

(Summarize client's evidence.)

After review of the evidence presented, I conclude that the original county decision was (correct) (incorrect). (Line through inappropriate word.) Your _____ benefits are:
(Program)

_____ approved _____
(Enter amount, effective date, etc.)

_____ reduced to _____
(Enter amount, deductible, and effective date, etc.)

_____ terminated _____
(Enter effective date.)

_____ denied.

The regulation(s) on which this decision is based is found in Section(s) _____
of the _____ Manual. This regulation(s) states that:

You may be required to repay benefits that you received for which you were not eligible.

If you are not satisfied with this decision, you may ask me orally or in writing for a State appeal hearing. I must receive your request on or before _____, which is 15 calendar days from the date this letter was mailed.

Sincerely,

Name : _____

Position: _____

Address: _____

Telephone #: _____