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 ● ZixMail: Medicaid.DSS.State.Appeals@dhhs.nc.gov

REQUEST FOR STATE APPEAL

(*To be completed by County DSS & submitted by ZixMail within 5 days of Appeal Request Date to* **Medicaid.DSS.State.Appeals@dhhs.nc.gov***)*

County: _____ **DSS Address:** _____
(If multiple county offices, be sure to indicate the correct office location)

DSS Worker: _____
Phone # _____ Ext._____
E-mail _____

DSS Supervisor: _____
Phone # _____ Ext._____
E-mail _____

Date of Appeal Request: _____ ☐ Check box if this is a duplicate to send updated or additional case information/evidence

Appellant: _____ SSN: _____

Address: _____ DOB: _____

City, State, Zip_____ Phone # _____

Sex: ☐ Male / ☐ Female Alternate Phone #_____

Date of Application: _____ PDC (IMC) # or PI Claim # _____

Indicate type of Hearing requested: (Must check one block - In accordance with **10A NCAC 21A .0304, Appellant must select the mode of the hearing at the time this State Appeal is requested**.)

☐ **In-Person Hearing at the county DSS office** (Hearing Officer & all parties present at the DSS)

☐ **Remote Phone Hearing** ☐ **Check when attempts to reach client to confirm mode are unsuccessful**
(Hearing Officer participates by phone and Appellant chooses to participate by using their own phone **or** by notifying the DSS that they will come to the DSS to participate with the county when the county connects by phone for the hearing.)

☐ **Remote Video Hearing using Microsoft TEAMS** – must include e-mail address for a video hearing - **e-mail address:** _____
(Hearing Officer participates by video and Appellant chooses to participate by connecting to Microsoft TEAMS *(must have internet access and camera & microphone capability)* **or** by notifying the DSS that they will come to the DSS to participate with the county when the county connects to Microsoft TEAMS for the video hearing.)

Representative: ☐ Yes or ☐ No (Check here ☐ if multiple representatives & attach a sheet to include contact information if more than one representative needs to be listed.)

Representative Name: _____

Title: *(Attorney, Hospital worker, Relative, Friend, etc.)* _____

Address: _____

Phone #: _____E-mail address: _____

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 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)*.

☐ Copy of local appeal hearing summary & decision, if applicable.

☐ Copy of D4037 Medicaid Disability Determination Transmittal from DDS, if applicable.

☐ Copy of DMA-5135 and all related medical records, if applicable. *(Appeal issue involves the medical decision made on an Emergency Medical Assistance claim.)*

☐ If PI, copy of completed DSS-1473A Addendum for Program Integrity

☐ If Expedited Medicaid Appeal, copy of completed DSS-1473B Addendum & Medical Evidence

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

☐ MAA	☐ Adoption Assistance
☐ MAA–Emergency Ser.MID # _____	☐ CAP/DA
☐ MAB	☐ CIP
☐ MAB–Emergency Ser.MID # _____	☐ LIEAP
☐ MAD	☐ Day Care
☐ MAD–Disagrees DDS disability decision	☐ FNS
☐ MAD- Emergency Ser.MID # _____	☐ FNS – SNAP (Simplified)
☐ MXP (Medicaid Expansion)	☐ FNS - Disaster
☐ MAF	☐ FNS-ADH (IPV Disqualification - PI)
☐ MAF–Emergency Ser.MID # _____	☐ FNS-IPV Overissuance (PI)
☐ MIC	☐ FNS-IHE Overissuance (PI)
☐ MIC–Emergency Ser.MID # _____	☐ FNS-AE Overissuance (PI)
☐ MPW	☐ SA
☐ MPW–Emergency Ser.MID # _____	☐ SAA
☐ MQB	☐ SAD
☐ Medicaid Transportation	☐ Work First
☐ NCHC	☐ Work First Program Integrity
☐ HCWD	☐ 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

_____	_____	_____
(DSS Worker Completing form)	*(Date completed)*	*(DSS Worker's direct phone #)*