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| **Date:** [DATE OF APPEAL DECISION] | **Decision made by:** [LME] |
| [BENEFICIARY OVER 21 OR LEGAL GUARDIAN] [ADDRESS LINE 1][ADDRESS LINE 2][CITY, STATE, ZIP] | Name: [BENEFICIARY NAME] |
| MID: [BENEFICIARY MID] |
| **I WANT A STATE FAIR HEARING TO APPEAL THIS DECISION** |
| **DIRECTIONS:** Please complete this form and mail or fax it to OAH and [LME NAME] at the addresses or fax numbers listed below. You must ask for your State Fair Hearing by [LAST DAY OF APPEAL PERIOD]*,* which is 120 days from the date of this notice. You can also make a phone call to request a State Fair Hearing. The phone number to request a State Fair Hearing is **1-984-236-1860**. You will still need to fill out and send this form after you call. |
| *Space intentionally blank* |
| **Office of Administrative Hearings (OAH)****Attention: Clerk of Court****1711 New Hope Church Road****Raleigh, NC 27609** **Fax: 984-236-1871** | **[LME NAME]****[ADDRESS LINE 1]****[ADDRESS LINE 2]****[CITY, STATE, ZIP]****[FAX NUMBER]** |
| You may ask for an expedited (faster) State Fair Hearing if you think your life, health, or ability to attain, maintain, or regain maximum function is in danger. **You must include documentation to support this request.** To ask for an expedited State Fair Hearing, please call **1-984-236-1860**. You may also check the box below and fax or mail this form to OAH along with your documentation. The address and fax number are at the top of this form. **□** I am requesting an expedited State Fair Hearing |
|  **□** I am requesting a free interpreter to assist during my appeal. My primary language is: □ Español □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| You may represent yourself in the hearing process. You may hire an attorney or use a legal aid attorney. You may ask a relative, friend, or other spokesperson (e.g. case manager) to speak for you. If you know now that another person will represent you during your appeal, please complete the box below. You may file your request now and identify a representative to help you at a later time. |
| I will *(PLEASE CHECK ONE)*: | **□ Represent** myself  | **□ Be** represented by someone else |
| **If you know now who your representative is, complete the section below:** |
| *Name of Representative:*  |  |
| *Relationship to You:*  |  |
| *Address:* |  |
| *Telephone:* |  |

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 Signature of Medicaid Recipient or Legal Guardian Date Telephone Number