



# Colorado

## Department of Personnel & Administration

Office of Administrative Courts

1525 Sherman Street, 4<sup>th</sup> Floor | Denver, CO 80203 | [www.colorado.gov/oac](http://www.colorado.gov/oac)

### REQUEST FOR STATE LEVEL HEARING

Section A - Contact Information		Section B – Representative Contact Information	
First Name	MI	<input type="checkbox"/> Check this box if you will have someone else represent you and complete the information below. Please read instructions.	
Last Name	Suffix	Attorney Reg No. (enter if your representative is a licensed attorney)	
Company		First Name	MI
Address		Last Name	Suffix
City	State	Zip	Company
Phone	Address		
E-Mail	City State Zip		
Date of Birth	CBMS or Health First #	Phone	E-Mail

### Section C - Appeal Information

I request a State Level hearing before an Administrative Law Judge. I am appealing the following adverse action: (Please check all that apply)

<input type="checkbox"/> Colorado Works/TANF	<input type="checkbox"/> Child Care Assistance	<input type="checkbox"/> Aid to Needy Disabled (AND)	<input type="checkbox"/> LEAP
<input type="checkbox"/> Old Age Pension (OAP)	<input type="checkbox"/> Subsidized Adoption	<input type="checkbox"/> Home Care Allowance	<input type="checkbox"/> Prior Authorization Denial
<input type="checkbox"/> Health First CO (Medicaid)	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Disability Determination (DDS)	
<input type="checkbox"/> Other _____			

What happened to your assistance?  Terminated  Application Denied  Recovery of overpayment  Amount Changed

Other \_\_\_\_\_

### Section D - Agency Information

Please indicate the county or agency that notified you of this adverse action below. Also, please attach a copy of any notice which you received from the county or agency notifying you of this action.

<input type="checkbox"/> County Department of Human or Social Services for _____	County
<input type="checkbox"/> State Department of Human Services	<input type="checkbox"/> State Department of Health
<input type="checkbox"/> Other _____	

If my home address or phone number changes, I will immediately notify the Office of Administrative Courts at the above address or telephone it at (303) 866-5626.

Appellant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# **Instructions for Completing the Request for State Level Hearing Form**

## **Section A - Contact Information**

The Office of Administrative Courts will need to know who you are and how we can contact you in order to open a case. Since you are the person appealing, you will be referred to as the Appellant. Please complete section A with your name, address and telephone number.

## **Section B - Representation**

This section is optional. In many cases involving benefits (Food Stamps, Medicaid, Old Age Pension, Home Care Allowance, etc) you can chose to be represented by someone regardless of whether they are a licensed attorney or not. If you wish to be represented by someone, you will need to check the first box in Section B indicating that you will be represented by someone and provide his or her name, address and telephone number. Your representative will need to send the OAC a letter stating, in writing, that they agree to represent you.

## **Section C - Appeal Information**

In order for us to open your case, we need to know what it is concerning. You should have received something from your County Department of Human/Social Services, the State Departments of Human Services or Health Care Policy and Financing, a local Community Center Board or other agency saying that you were denied a benefit or a benefit you have is being terminated or reduced. The OAC will need to know what that benefit is and also what action (termination, reduction, etc) occurred.

## **Section D - Agency Information**

The OAC also needs to know what agency made the decision to deny, terminate or reduce your benefit. You will need to enter this information in Section D

**Finally, you must sign the form in order for the OAC to open a case for you.**

If available, please attach copies of any notices or letters you received from the agency regarding the denial, termination or reduction of benefits.

Appeals should be mailed to:

Office of Administrative Courts  
1525 Sherman Street 4<sup>th</sup> Floor  
Denver, CO 80203

Or, if less than 10 pages, it can be faxed to **303-866-5909**.

In most instances the OAC will process your appeal within 5 business days. Your Notice of Appeal will generally be mailed to you within 14 days of the date the OAC received your request for hearing. In most cases, you will receive a Notice of Hearing specifying the date, time and location of your hearing at least 30 days prior to the hearing date.

If you have additional questions, you can call the General Services Clerks at 303-866-5626.