DISTRICT OF COLUMBIA
OFFICE OF ADMINISTRATIVE HEARINGS
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WASHINGTON, DC 20001-2714
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Request to Appeal a Healthcare Coverage Decision or Action by the Department of Health Care Finance (DHCF) or DHCF's Contractor

Use this form if you want a hearing before an Administrative Law Judge because you disagree with a decision, action, or inaction by DHCF or its contractor regarding healthcare coverage under ***Medicaid, the Elderly and Persons with Physical Disabilities (EPD) Waiver Program, or DC Healthcare Alliance****.* ***Attach a copy of the decision if you have one****. If you would like to appeal a decision regarding* ***financial eligibility for one of these programs****, please use the form titled* ***Request to Appeal a Department of Human Services (DHS) Decision****.*

Section 1 – Contact Information

Print Your Name:	Your Mailing Address:
Your Telephone:	
Your Email Address (*if any*): ☐ I consent to receive documents by email only	Your Ward (*if you know*):
If you have a representative for this case or if you have a case manager (check which apply): ☐ Non-Attorney Representative ☐ Attorney ☐ Case Manager	
Name of Representative or Case Manager:	Address of Representative or Case Manager:
Telephone:	
Email Address: ☐ Consents to receive documents by email only	Agency (*if any*):

Section 2 – Benefits Information

My appeal concerns the following (select one):

☐ Medicaid ☐ EPD Waiver ☐ Medicaid and EPD Waiver ☐ DC Healthcare Alliance

Medicaid, EPD Waiver, or Alliance ID Number (if you know): _____

Name of Medicaid, EPD Waiver, or Alliance Provider (if you know): _____

(see reverse)

Section 3 – Why do you need a hearing?

Check all the boxes that apply to your case:

☐ I requested **medical or dental services, equipment, or supplies** (for example, hospitalization, surgery, dental implants, wheelchair, prescriptions, etc.) under the Medicaid, EPD Waiver, or Alliance program. I have not received the requested services, equipment, or supplies.

Please explain: _____

☐ I have been **denied or have not received personal care aide (PCA) services** under the Medicaid or EPD Waiver program.

☐ I have been **denied** a requested **increase** in PCA services under the Medicaid or EPD Waiver program.

☐ My **recertification** for PCA services under the Medicaid or EPD Waiver program **is delayed.**

Date that certification period ended (or will end): _____

☐ My PCA services under the Medicaid or EPD Waiver program **have stopped or are about to stop.**

Date that benefits stopped (or will stop): _____

☐ My PCA services under the Medicaid or EPD Waiver program **have been reduced or are about to be reduced.**

Date that benefits were (or will be) reduced: _____

PCA hours I was getting: _____ Proposed new level of PCA hours: _____

☐ **Other** (please explain): _____

Section 4 – Language Access

Do you need OAH to provide an interpreter to help you participate in the hearing?

☐ YES ☐ NO

If YES, what language do you need? _____

Section 5 – Reasonable Accommodation

Do you need a reasonable accommodation to help you participate in the hearing?

☐ YES ☐ NO

If YES, please explain: _____

Section 6 – Who Prepared the Hearing Request?

Signature of the person who prepared the hearing request (unless the request was by phone):

_____ _____ _____

Signature Print Name Date

Email, telephone, mailing address of person who prepared hearing request (if not printed above):

_____

_____

Do not fill out this box. The OAH Clerk's Office will fill it out.

Received by_____ Date:_____