FORM TO FILE A STATE HEARING

You can ask for a State Hearing by calling: 1-800-952-5253.
TDD users, call 1-800-952-8349.
Or you can fill out this form and FAX it to State Hearing Support at 916-651-5210 or 916-651-2789**.**

Or you can mail this page to: California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 19-17-37
Sacramento, CA 94244-2430

For free help filling out this form, call the legal help phone number listed on 'Your Rights.'

I do not agree with the decision about my health care. Here's why:

_____
_____
_____
_____
_____

(If you need more space, use another piece of paper. Make a copy for your records.)

Check these boxes only if they apply to you:

(1) ☐ I want the person named below to represent me. She/he can see my medical records that relate to this hearing, come to the hearing, and speak for me.

Name: _____
Address: _____ Phone Number: _____
_____

(2) ☐ I need a free interpreter. My language or dialect is:
_____

(3) ☐ I also want to file a grievance against the health plan. I understand the State will send my health plan a copy of this form.

(4) ☐ My situation is **urgent**. I need a quick decision and cannot wait 90 days because: (Explain what may happen without a quick decision. As discussed in the "Your Rights" information notice, you will also need a letter from your doctor or health plan if you want an expedited hearing).

_____
_____
_____
_____
_____
_____

(5) ☐ Please continue the service my Plan has stopped until my hearing.

My Name: _____ My Social Security Number: _____
Address: _____
_____ Phone Number: _____

My signature: _____ Today's Date: _____
(After you complete this form, make a copy for your records.)