

DEPARTMENT OF PERSONNEL & ADMINISTRATION

633 17th Street, Suite 1300
Denver, Colorado 80202

Office of Administrative Courts

Phone (303) 866-2000
Fax (303) 866-5909
www.colorado.gov/dpa/oac

REQUEST FOR STATE LEVEL HEARING

Appellant's Name: _____

Representative's Name: _____
(if any)

- a. Check here if you authorize the Office of Administrative Courts (OAC) to provide your representative with information regarding your case. This information may include potentially sensitive medical or personal information from your file.
- b. Check here if you wish your representative to receive correspondence, notices, decisions, etc from the court in your stead.

The OAC will need to contact you to let you know when your hearing will take place. If you are making this request and do not have someone else representing you, please enter your contact information below. If you do have a representative and marked box b above, please enter your representative's contact information below.

Address: _____

City: _____ State: _____ Zip: _____ Household #: _____

Primary Phone: _____ Secondary Phone: _____

I request a State Level hearing before an Administrative Law Judge. At the hearing, I will appeal the adverse action(s) taken as follows:

Please indicate which type(s) of assistance have been affected?

- | | | | |
|--|--------------------------------------|--|---|
| <input type="checkbox"/> Trails Registry | <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Colorado Works/TANF | <input type="checkbox"/> Day Care Licensing |
| <input type="checkbox"/> Aid to Needy Disabled (AND) | <input type="checkbox"/> LEAP | <input type="checkbox"/> Child Care Assistance | <input type="checkbox"/> Old Age Pension (OAP) |
| <input type="checkbox"/> Subsidized Adoption | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicaid Long Term Care | <input type="checkbox"/> Disability Determination (DDS) |
| <input type="checkbox"/> Home Care Allowance | <input type="checkbox"/> PAR Denial | | |
| <input type="checkbox"/> Other _____ | | | |

What happened to your assistance?

- Terminated Application Denied Recovery of overpayment Amount Changed
- Other _____

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.

County Department of Human or Social Services for _____ County
(County Name)

Who have you been working with at the county? _____
(County Worker's Name)

What is their phone number? _____

- State Department of Human Services
- State Department of Health Care Policy and Financing
- 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: _____

Please complete this form and mail it to: Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, CO 80202

Purpose of this form: The Office of Administrative Courts has made this form to help people asking for a hearing to identify what has happened or will happen to their benefits. This form is not a substitute for the official notice. When you submit this form, please include any official notices (CBMS notices, Notices of Proposed Action, etc.) that you may have received regarding your benefits. Please refer to that notice for a description of the action, for any deadlines to appeal and for any other information required by agency rule.