



Colorado

Department of Personnel & Administration

Office of Administrative Courts

1525 Sherman Street, 4th Floor | Denver, CO 80203 | www.colorado.gov/oac

REQUEST FOR STATE LEVEL HEARING

Section A - Contact Information

First Name _____ Last Name: _____ Middle Initial _____ Suffix _____

Company _____

Address _____

City _____ State _____ Zip _____ Phone _____

E-mail _____

Date of Birth _____ CBMS or Medicaid #: _____

Section B - Representation

Check this box if you will have someone else represent you and complete the information below. Your representative will need to send the OAC a statement in writing that they agree to represent you.. If you will not be represented by another person, please proceed to Section C below

Is the representative a licensed attorney? Yes No Attorney Reg. # _____

First Name _____ Last Name: _____ Middle Initial _____ Suffix _____

Company _____

Address _____

City _____ State _____ Zip _____ Phone _____

E-mail _____ Relationship to Appellant: _____

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"/> 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 _____

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.

- County Department of Human or Social Services for _____ County
- 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: