

# Adult Care Home Hearing Request Form

## TO BE COMPLETED BY THE FACILITY

Resident: \_\_\_\_\_

Facility: \_\_\_\_\_

Date of Transfer/Discharge Notice: \_\_\_\_\_

Date of Scheduled Transfer/Discharge: \_\_\_\_\_

I would like to request a hearing to appeal the above resident's notice of transfer/discharge. I would like for the hearing to be held (please check one):

By telephone

In person in Raleigh, NC

Name of Person Requesting Hearing: \_\_\_\_\_

Relationship to Resident: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

(The signature of resident or family member or legal representative authorizes release of medical records)  
If you have questions, you may contact the DHHS Hearing Office by calling (919) 814-0090.

PLEASE COMPLETE THE ABOVE INFORMATION AND **ATTACH A COPY OF THE NOTICE OF TRANSFER OR DISCHARGE** THAT WAS ISSUED TO YOU BY THE FACILITY. YOUR REQUEST MUST BE **RECEIVED NO LATER THAN ELEVEN (11) CALENDAR DAYS** FROM THE DATE OF THE NOTICE OF TRANSFER/DISCHARGE. YOUR REQUEST FORM SHOULD BE SUBMITTED TO:

DHHS  
Hearing Office  
2501 Mail Service Center  
Raleigh, NC 27699-2501  
Fax: (919) 882-1179  
Email: [Medicaid.Hearings@dhhs.nc.gov](mailto:Medicaid.Hearings@dhhs.nc.gov)

Informational webinars regarding the Transfer/Discharge hearing process can be found at <https://medicaid.ncdhhs.gov/medicaid/administrative-hearings-appeals>