

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) 814-0032
Email: Medicaid.HearingOffice@dhhs.nc.gov**

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