OAH Case No. _____
DHS Case No. _____
(Official Use Only)

APPEAL REQUEST FOR INDIVIDUAL/FAMILY HEALTH COVERAGE

If you are dissatisfied with actions taken for another ESA program (TANF, Food Stamps, IDA, etc.), you must use another form or call the phone number listed at the bottom of this form.

NAME (Appellant): _____ **DATE:** _____

TELEPHONE #: _____

		Mailing Address (If Different)
ADDRESS:	_____	_____
	_____	_____
	_____	_____

Section 1 I am requesting a hearing because I disagree with the following action(s): (check all that apply)

Dep't of Human Services	**Health Benefit Exchange Authority**
a) __Medicaid Denial b) __Medicaid Termination	a) __Special Enrollment Period (SEP) Denial b) __Reinstatement Denial (Private Health Plan) c) __Effective Date (a.k.a. "start date") Change Denial d) __Voluntary Termination Date (a.k.a. "end date") Denial e) __Premium Tax Credit (APTC) Denial or Calculation f) __Cost-Sharing Reduction (CSR) Denial or Calculation g) __Enrollment Denial (Private Health Plan through DC Health Link)

Section 2 How do you want the agency's decision to be changed? _____
_____
_____

Section 3 Are there others in your household whose benefits determination you are appealing? If so, list their names here: _____
_____
_____

Section 4 – APTC/CSR Cases Only: *[DO NOT USE THIS SECTION FOR A MEDICAID APPEAL]*

How much APTC where you approved for? $ _____ max/month (Please check if None): ☐
How much CSR where you approved for? _____% (Please check if None): ☐

(TURN SHEET OVER)

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Check here if you want to receive APTC/CSR while your appeal is pending. ☐

NOTE: If you select this option, and the result of your appeal is that you are determined eligible for less, or no premium tax credit, the amount you received while your appeal is pending may lead to you owing more federal taxes or it may reduce the refund you would have otherwise received.

Section 5 – Special Needs (OPTIONAL) - Check any special services that you would need to help you participate in the hearing:

☐ I need an interpreter
- What Language? _____

☐ I need to participate in the hearing by telephone for the following good reason(s)._____
_____
_____
- What telephone number should we call to contact you for the hearing?_____

☐ I need another service
- What type of service do you need?_____

EMERGENCY/EXPEDITED REQUEST

☐ Check here if your life, health, or ability to attain, maintain, or regain maximum function is currently in jeopardy because you have an immediate need for health services. ***If so, you must attach documentation (such as a doctor's note) explaining the immediate need. Failure to do so will result in your appeal being handled on a standard schedule.***

Section 6 – Contact Information

Attorney/Representative (if any):

Name: _____
Address: _____
_____
City, State, Zip:_____
Telephone #: _____

Person preparing request (if other than applicant):

Print name: _____
Office/Center: _____
Telephone #: _____

I'm signing this appeal request under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that the submission of a false statement on this form is a crime punishable under D.C. Official Code § 22-2405. I also attest that I have permission from all of the people listed in Section 3 to submit an eligibility appeal request on their behalf.

Signature: _____ **Date:** _____

SEND BY U.S. MAIL, E-MAIL, OR FAX TO:

Office of Administrative Review and Appeals
64 New York Avenue NE, 5th Floor
Washington DC 20002

E-MAIL: DC.OARA@DC.GOV
FAX: (202) 724-2041
PHONE: (202) 698-3907

Version Date: 10/27/15