NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

REQUEST FOR FAIR HEARING / APPEAL

Please look at the attached instructions for information about completing each section. Please fill out both pages.

SECTION 1: Contact Information for the Person Requesting an Appeal

Please provide information for the person receiving services or the provider.

First Name:	Middle Initial:	Last Name:

Date of Birth:	Social Security Number/Medicaid ID
Mailing Address:	City, State, Zip Code:
Phone Number:	Email Address (optional):

SECTION 2: Reason for Your Appeal

A list of benefits to appeal is in the attached instructions. You can attach more pages if you need more space. You may attach documents that support your appeal.

I am appealing because

SECTION 3: Appeal Information (Check All that Apply)

☐ I received a Notice of Action/Decision from the Department dated _____ (optional)
Optional. You can attach a copy of the Notice if you are unsure.

☐ I have not received a notice from the Department. I submitted my application dated_____.
(Providing this date is optional.)

☐ I am requesting an expedited appeal, if available, because:

_____

SECTION 4: Benefits/Services During Your Appeal

If you are receiving benefits, you may continue receiving the benefits/services while your appeal is ongoing.

☐ I DO want my benefits/services to CONTINUE during my appeal, if possible.

☐ I DO NOT want my benefits/services to CONTINUE during my appeal.

SECTION 5: Type of Hearing and Accommodations

Your hearing will be in English by default. If you prefer another language (including ASL) or need to request another accommodation, then check the boxes that apply. These services will be provided at no cost.

- ☐ I would like an interpreter for the following language:_____
- ☐ I have trouble reading and need oral interpretation services.
- ☐ I need help because I am:
  - ☐ Blind
  - ☐ Deaf or hearing impaired
  - ☐ and/or:_____

SECTION 6: Representative

During the appeal hearing, you can represent yourself. If you would like someone else to assist you during your appeal, at your own expense, then check the next box.

☐ I WANT the following person to assist me with my appeal. I am responsible for asking my representative to help me. I understand that this selection does not constitute an authorization for release of information. If I want my representative to have access to my private information, I may need to complete form HHS-160.

First Name:	Last Name:
Street Address:	City, State, Zip Code:
Phone Number:	Email Address (optional):

This person is my:

- ☐ Power of Attorney
- ☐ Legal Guardian
- ☐ Attorney
- ☐ Other:_____

You can attach documents such as a Power of Attorney or order of guardianship (if needed).

SECTION 7: Signature:

Signature:	Date:

Print name:

I am signing as:

- ☐ Myself
- ☐ A Power of Attorney
- ☐ A Court-Appointed Guardian
- ☐ An Attorney
- ☐ An Authorized Representative (MLTC-35)
- ☐ A Parent of a Minor Child

SUBMITTING YOUR REQUEST FOR FAIR HEARING

- By Email: DHHS.Hearingoffice@nebraska.gov
- By Mail: PO Box 98914, Lincoln, NE 68509-8914
- By Fax: (402) 742-2376

INSTRUCTIONS FOR COMPLETING THE "REQUEST FOR FAIR HEARING" DOCUMENT AND IMPORTANT INFORMATION

SECTION 1: CONTACT INFORMATION

- Name: Enter the name and address of the person who applied for benefits or receives benefits.
  - If you are a provider, enter the name associated with your provider number.
- Mailing Address: Enter an address where you can receive mail. The Department will mail notices to this address.
- Email: If you give us your email address, you will receive notices and updates to your email. You will still get a copy in the mail. You can change your mind and stop getting a copy in your email by contacting us or the Hearing Office, (402) 471-7237.

SECTION 2: REASON FOR APPEAL

- Program/Assistance: Write the program or type of assistance related to your appeal. Below are some programs and benefits:

For Individuals

- Behavioral Health Services
- Assistance to the Aged, Blind, and Disabled (AABD)
- Aid to Dependent Children (ADC)
- Low Income Home Energy Assistance (LIHEAP)
- Supplemental Nutrition Assistance Program (SNAP)
- State Disability Program/State Review Team
- Home and Community Based Services Waivers (Aged and Disabled Waiver, CBD Waiver, TBI Waiver)
- Developmental Disability Services
- Public Health Services
- Refugee Resettlement Program
- Child/Adult Abuse Neglect Central Registry
- Child Care Subsidy
- Child Support Enforcement
- Emergency Assistance
- Employment First
- Medicaid/Medical Assistance

For DHHS Providers

- Behavioral Health Services
- Foster Care
- Child Care Services
- SSAD/PASS Services
- Developmental Disabilities Services
- Medicaid Medical Services
- Medicaid Waiver Services
- Public Health Services

- Reason for Appeal: Please write the specific reason you are appealing the decision made by the Department. You may attach documents to your appeal to help explain why you disagree.

SECTION 3: APPEAL INFORMATION

- Notice: You may have received a "Notice of Action" or "Notice of Decision" in the mail. This document contains your case number and information about your application or benefits that may be useful to complete this form.
  - At the top of the Notice, there will be a date. Put this date in the section.
    - If you have received multiple Notices, check that the notices are for the same master case number. If the notices are for the same master case number, please include the dates of each notice.
  - If you do not have a notice, then select the box that indicates you did not receive one. Enter the date you sent in your application. If there is no application, then explain why you are appealing in the space provided or on a separate piece of paper attached to your Request for Fair Hearing.
  - Please attach a copy of the Notice to your Request for Fair Hearing, if possible.

- Expedited (Faster) Appeal: You may request a faster appeal if you feel that you cannot wait for a normal decision. You may request a faster appeal if waiting would cause:
  - A risk of serious health problems or death; or
  - Limit your ability to attain, maintain, or regain maximum function.

SECTION 4: BENEFITS/SERVICES DURING APPEAL

- Continuing Benefits/Services:
  - If you file your appeal within the allowed timeframe for the program, you may continue to receive your current level of assistance pending the appeal decision. If the decision is not in your favor, you may have to repay the benefits.
  - If you lose your appeal, you may have to pay back the cost of the benefits/services you received during your appeal.
- You can choose not to continue to receive benefits by checking the box.

SECTION 5: HEARING ACCOMMODATIONS

- Checking the box for telephone or in person notifies the Department of your preference.
- If you attend "in person" at your local Department office, the hearing officer and other parties may appear for the hearing by phone or videoconferencing.
- Interpreters: A language interpreter may be provided at your request to help with your appeal at no cost to you. This includes sign language interpreters. Please write the specific language you need in the space provided.

SECTION 6: REPRESENTATIVE

- Naming a Representative:
  - You do not have to give anyone the ability to help with your appeal.
  - If the representative is a power of attorney or guardian, please submit a copy of the power of attorney or order appointing guardian with the appeal.
  - By identifying a representative, you are not granting the Department leave to release private information to the representative. If you want the person to have access to private information, please complete Form HHS-160 and submit it with your Request for Fair Hearing.
  - If you have previously appointed an Authorized Representative for Medicaid (meaning you submitted a MLTC-35), you may not need to submit a Form HHS-160 for your representative to access your information.

SECTION 7: SIGNATURE

- If you are a power of attorney or guardian signing this form, you will need to submit a copy of the power of attorney or court order with this form if you have not submitted the documents to DHHS before.
- An Authorized Representative can be appointed for Medicaid benefits using Form MLTC-35, Designation of Authorized Representative.

PROCEDURES FOR A FAIR HEARING

- A request for a fair hearing may also be made in the form of a simple letter or written request to the DHHS Hearing Office, P.O. Box 98914, Lincoln, Nebraska 68509-8914 or DHHS.HearingOffice@nebraska.gov. The request must be made in writing.
- The person appealing will receive a notice from the Hearing Office with the date of the hearing. The notice will include the location or the teleconference instructions.
- The hearing is held by a Hearing Officer. Both the person appealing and DHHS may ask witnesses to appear to provide testimony. The personal appealing and DHHS may submit documents and other evidence for consideration.
- A complete report of the hearing is made to the Director of the Nebraska Department of Health and Human Services by the Hearing Officer.
- A written decision by the Director of the Nebraska Department of Health and Human Services is transmitted to both the person appealing and the appropriate local office.