How to File For a State Fair Hearing after an Appeal:

If you asked for an appeal after receiving the Notice of Adverse Determination form and you do not agree with the appeal decision, you have the right to ask for a state fair hearing. You must ask for a hearing no later than 120 days from the date on the front of the Notice of Adverse Determination Form.

How to Continue Your Services during the State Fair Hearing Process:

If you have previously requested to continue your services while you applied for an appeal, your services will continue during the state fair hearing process, if *all* of the following are met:

- You filed the request for an appeal within 60 days of the date of on the Notice of Adverse Determination Form.
- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- You requested to have your services continue within 10 calendar days of the date on the Notice of Adverse Benefit Determination.

To Keep Your Same Services While You File For A State Fair Hearing:

- You must have previously filed for an appeal and asked to continue your services within 10 days from the date marked on the Notice of Adverse Determination Form.
- If you requested to continue your services during the appeal process, your Medi-Cal mental health services will stay the same until one of the following occurs:
    - You withdraw the appeal or state fair hearing request.
    - You fail to request continuation of services within the allotted timeframe.
    - You receive a decision on your state fair hearing that upholds the original decision on the Notice of Adverse Benefit Determination form.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

- Call toll free: 1-800-952-5253
- If you are hearing impaired and use TDD, call: 1-800-952-8349

Authorized Representative
You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.)
The information you are asked to write on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the California Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (as referenced under "**To Get Help**"). Any information you provide may be shared with Yolo County HHSA, the State Department of Public Social Services and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2).

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out the "HEARING REQUEST" form on the following page. *Make a copy of the front and back for your records,* then send the completed form to the address below; or call 1-800-952-5253, and TDD 1-800-952-8349 for hearing impaired; or submit a request online at:
https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx

California Department of Social Services
State Hearing Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by my Mental Health Plan, Yolo County Health Human Services Agency, Behavioral Health.

☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

My Name: (print) _____

My Social Security Number: _____

My Address: (print) _____

My Phone Number: **( )** _____

My Signature: _____ **Date:** _____

I need an interpreter at no cost to me. My language or dialect is:

_____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name: (print) _____

Address: (print) _____

Phone Number: **( )** _____