

HOW TO REQUEST AN APPEAL HEARING

◆ How do I request an appeal hearing?

Complete the attached form and mail to:

Attendant Care Program-Appeal Request,
217 E. Redwood Street, Suite 1300, Baltimore, MD 21202.

If you need assistance completing the form, you may call 410-767-3660 to request help.

◆ How long do I have to request a hearing?

You must request a hearing within **30 days of the date of this notice**. The request for an appeal hearing must be post-marked or received in our office by the deadline. The same deadline applies whether you are a new applicant who has been denied participation in the Attendant Care Program or a past participant who has been denied participation as part of the annual renewal process.

◆ Where and when will the hearing be held?

The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

◆ Do I have to come to the hearing?

Yes. If you can't come, call the Office of Administrative Hearings to find out how to reschedule your hearing.

◆ Can I bring someone to help me speak or to speak for me?

You can represent yourself or have a lawyer represent you. No individual is required to have an attorney. The Legal Aid Bureau, Inc., which you can call at 1-800-999-8904, provides free legal help to certain people who meet its eligibility requirements.

◆ How do the hearings work?

The Office of Administrative Hearings has rules of procedure which direct how hearings work. These rules of procedure are on-line at:

http://www.dsd.state.md.us/comar/subtitle_chapters/28_Chapters.htm. Go to "Subtitle 2 Rules of Procedure" for a list of and links to each regulation and rule.

◆ Where can I get more information about how hearings at the Office of Administrative Hearings work?

The Office of Administrative Hearings has a website with general information:

<http://www.oah.state.md.us/> The Frequently Asked Questions page (<http://www.oah.state.md.us/faq.asp>) is also helpful for you to review.

REQUEST FOR HEARING

Fill out this form **ONLY** if you disagree with a decision concerning your ability to participate in the Attendant Care Program. You may call 410-767-3660 if you would like us to help you fill out this form.

1. Tell us who you are. Please print clearly.

Name: _____ **Date of Birth:** _____

Address: _____

City/County: _____ **State:** _____ **Zip Code:** _____

Social Security Number _____ **Phone:** _____

2. What is the reason you are requesting a hearing?

☐ **My application for participation in the Attendant Care Program was denied.**

☐ **My annual review for continued participation in the Attendant Care Program was denied.**

☐ **I was terminated or suspended from the Attendant Care Program.**

☐ **My reimbursement amount was decreased.**

☐ **Other Reason (Please explain below)**

Please explain why you disagree with the decision.
