# FORM TO FILE A STATE HEARING

To contact scopes unit to check status of an appeal call **916-651-8889** or **855-266-1157** toll free. Email appeals to scopeofbenefits@dds.ca.gov or fax to **916-651-2727**.

Or you can mail this page to:

California Department of Social Services
State Hearing Division
744 P St. Mail Station 9-17-37
Sacramento, CA 95814

For free help filling out this form, call the legal help phone number listed on 'Your Rights.'

**I do not agree with the decision about my health care. Here's Why:**

_____

_____

_____

(If you need more space, use another piece of paper. Make a copy for your records.)

**Check these boxes only if they apply to you:**

(1) ☐ I want the person named below to represent me. She/he can see my medical records that relate to this hearing, come to the hearing, and speak for me.

Name: _____ Phone No: _____

Address: _____

(2) ☐ I need a free interpreter. My language of dialect is: _____

(3) ☐ I also want to file a grievance against the health plan. I understand the State will send my health plan a copy of this form.

(4) ☐ My situation is **urgent.** I need a quick decision and cannot wait 90 days because: (Explain what may happen without a quick decision. As discussed in the "Your Rights" information notice, you will also need a letter from your doctor or health plan if you want an expedited hearing).

_____

_____

_____

(5) ☐ Please continue the service my Plan has stopped until my hearing.

My Name: _____ My Medi-Cal ID# or SS#: _____

Address: _____ Phone No: _____

My Signature: _____ Today's Date: _____

*(After you complete this form, make a copy for your records.)*