



**For questions about Medicare**, please call 1-800- MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week or visit [www.medicare.gov](http://www.medicare.gov) TTY users should call 1-877-486-2048.

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### **Appeals Rights and Deadlines**

You have a right to a hearing if you disagree with a decision we have made. You have thirty (30) days from the date you receive this letter to request an appeal. If you do not request an appeal, you may lose the right to a hearing. Please see the enclosed appeal form for complete instructions.

After completing Sections I and II on the enclosed form,

Please **MAIL** to:

EOHHS/ Medicare-Medicaid Plan [This address is for mail only.]  
Hazard Building LL B23, 74 West Road  
Cranston, RI 02920-8409

OR **FAX** to: (401) 462-3158

If you need help in person or to hand deliver your appeals form, please go to a local Rhode Island Department of Human Services (DHS) Office. If you have questions about completing the form or locating a DHS Office, please call the Medicare-Medicaid Plan Enrollment Line at 1-844-602-3469 (TTY 711), Monday – Friday 8:30 am – 7:00 pm, Saturday 9:00 am – 12 noon.

[Insert appeals form here]

[<Marketing Material ID: 009 DENIAL OF ENROLLMENT>]



Agency Date Stamp

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES



Hearing Office Date Stamp

DHS-121 Rev.10-14

REQUEST FOR A HEARING

SECTION I. IDENTIFYING INFORMATION – Please Print

Name Recipient Social Security Number

Address Number and Street City/Town State ZIP

WHAT LANGUAGE DO YOU SPEAK?

SECTION II. STATEMENT OF COMPLAINT (To be completed by applicant or recipient)

MY APPEAL IS ABOUT: RIW MEDICAID ASST. GPA SNAP CHILD CARE OTHER

IF THE HEARING DECISION IS NOT IN MY FAVOR, I UNDERSTAND THAT I MUST REPAY ANY ASSISTANCE AND/OR FOOD STAMPS FOR WHICH I AM DETERMINED INELIGIBLE.

Signature (Recipient) Date

SECTION III. STATEMENT OF AGENCY POLICY (To be completed by the Agency Representative)

THE APPEAL IS ABOUT: RIW MEDICAID ASST. GPA SNAP CHILD CARE MART DECISION

Indicate Specific DHS/FS Manual Reference: Section(s)

Explain agency decision in relation to complaint and policy:

Agency Representative (Signature) (Print Name)

Supervisor (Signature) (Print Name)

Regional Manager

Local Office

Also Send Copies of the scheduled appointment for this Hearing Request to:

AGENCY: MA DISABILITY ONLY CASES: Attach Copy of InRhodes Adverse Action Notice ALL OTHER CASES: Bring Notice to Hearing

## INSTRUCTIONS FOR COMPLETING DHS-121

This form is used by both the client and the agency representative to:

1. Identify in writing by the client the cause of his/her appeal; and
2. Identify, by the agency representative, the policy on which the decision causing the appeal was based.

The client receives this form at the time of notification of an Agency decision.

**For Supplemental Nutrition Assistance Program (SNAP):** A client has **90** days from the mail date of the Notice of Agency Action to request a hearing.

**For General Public Assistance (GPA):** A client has **10** days from the mail date of the Notice of Agency Action to request a hearing.

**For All Other Programs:** A client has **30** days from the mail date of the Notice of Agency Action to request a hearing.

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### Sections I and II

These two sections can be filled out by the client alone, or by the client and agency representative, if the client needs help in completing the form. The person requesting an appeal signs this section and returns the completed form to the appropriate regional or district office.

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### Section III

After Sections I and II are completed, the agency representative completes Section III, citing the agency policy(ies) with reference to the particular manual section(s) that was the basis for making the decision. This section is signed by the agency representative and supervisor. The area identifying the local office is completed. The form is routed promptly to the hearing office at Central Office.

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**NOTE:** When the DHS-121 is completed by the client and mailed directly to Central Office, without being routed through the regional or district office, the hearing office makes a copy of the DHS-121. The original is sent to the regional or district office for completion of Section III. The DHS-121 must be returned to the hearing office at Central Office within seven (7) days.

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### Legal Help

At the scheduled hearing, you may represent yourself, or be represented by someone else such as a lawyer, a relative, a friend, or another person. If you want free legal help, call Rhode Island Legal Services at 274-2652 (outside the Providence calling area, call toll free at 1-800-662-5034).

