

# Appeal Request Form

DS 1821 (Rev. 03/2023)

## HOW TO APPEAL

- You may submit the form electronically at the DDS website:  
<https://bit.ly/DDSAppealForm>
- You may send the attached form by email to [AppealRequest@dds.ca.gov](mailto:AppealRequest@dds.ca.gov)
- You may send the attached form by mail to 1215 O Street MS 8-20, Sacramento, CA 95814
- You may send the attached form by fax to 916-654-3641

You must file your appeal request on time. There are two deadlines.

- The first deadline is for if you want to keep your current services the same during your appeal:
  - Your request must be postmarked or received by DDS no later than 30 days from when you got your NOA and before the action takes place.
  - Keeping your current services during an appeal is called aid paid pending.
- The second deadline is for all other appeal requests. If your appeal request is filed 31 to 60 days from when you got your NOA, the regional center's decision will happen while your appeal continues. Appeal Requests must be postmarked or received by DDS no later than 60 days after the date you got the NOA or Good Faith Belief Letter.

## WHERE TO GET HELP

You may get help with your appeal request. People who can help you are:

- Your service coordinator or other regional center staff, if you ask them.
- Your clients' rights advocate (CRA) at:
  - (800) 390-7032 for Northern California, or
  - (866) 833-6712 for Southern California, or
  - Find the clients' rights advocate at your regional center here:  
[www.disabilityrightsca.org/what-we-do/programs/office-of-clients-rights-advocacy-ocra/ocra-staff-links](http://www.disabilityrightsca.org/what-we-do/programs/office-of-clients-rights-advocacy-ocra/ocra-staff-links)
- The [Ombudsperson](#) Offices at (877) 658-9731 or [ombudsperson@dds.ca.gov](mailto:ombudsperson@dds.ca.gov). If you are in the Self-Determination Program email [sdp.ombudsperson@dds.ca.gov](mailto:sdp.ombudsperson@dds.ca.gov) instead.
- You also may get help from a Family Resource Center: <https://frcnca.org/get-connected/>.
- Your regional center may help you find a local parent support group or community-based organization that may help you.
- If you live at Porterville Developmental Center, Canyon Springs, or a STAR Home, you may also get help from the State Council on Developmental Disabilities:
  - Canyon Springs, Desert STAR, South STAR (760) 770-0651
  - Porterville and Central STAR (559) 782-2431
  - Headquarters (408) 834-2458
  - <https://scdd.ca.gov/clientsrightsadvocates/>

**The “Appeals Information Packet” is found using the QR code or the link. They provide additional information about the appeal process.**



<https://bit.ly/AppealInfoPacket>

**Confidential Client Information, California Welfare and Institutions Code Sections 4514 and 5328,  
Health Insurance Portability and Accountability Act**

**This Appeal Request is for the following person:**

\* Required Fields

\*First Name:  \*Last Name:  \*Date of Birth:  Unique Client Identifier (UCI), if any:

\*Street Address:  Apartment number:

\*City:  \*Zip:

**\*One method of contacting you is required. Providing an email address helps us serve you faster.**

Primary Phone Number:  Secondary Phone Number:  Email Address:

\*How do you prefer we contact you?

\*What regional center is this appeal about?

\*Do you need an interpreter?  Yes  No

\*What language do you prefer?

**\*The appeals process has three parts. You may use one or more of these parts. If you don't resolve your disagreement using one part, you may decide to use other parts later. Choose the parts you want to use below. Note: If you select video below, you must supply an email address.**

<input type="checkbox"/> <b>Informal meeting</b>	You meet with the regional center director or someone they choose. You and the regional center will try to resolve your appeal. <b>I want my informal meeting to be:</b> <input type="checkbox"/> In person; <input type="checkbox"/> by video; and/or <input type="checkbox"/> by telephone
<input type="checkbox"/> <b>Mediation</b>	You and the regional center meet with a mediator. The mediator is an impartial person. The mediator helps you and the regional center make an agreement about your appeal. <b>I want my mediation to be:</b> <input type="checkbox"/> In person; <input type="checkbox"/> by video; and/or <input type="checkbox"/> by telephone
<input type="checkbox"/> <b>Hearing</b>	Your hearing is with a Hearing Officer. The Hearing Officer listens to information from you and the regional center. The Hearing Officer helps you bring out your facts. The Hearing Officer makes the hearing fair and informal. The Hearing Officer then makes a decision about your appeal. <b>I want my hearing to be:</b> <input type="checkbox"/> In person; <input type="checkbox"/> by video; and/or <input type="checkbox"/> by telephone

\*Did you receive a document from the regional center that you would like to appeal?

If yes,

If you received a Notice of Action (NOA), what date did you receive it?

Do you believe you are eligible to keep your current services? This is called "aid paid pending".

Yes  No

\*Proposed action being taken by the regional center (check all that apply):

- Eligibility Denial
- Eligibility Termination
- Service Denial
- Service Reduction
- Service Termination

What is the proposed effective date of the regional center action?

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**\*Reason(s) for this Appeal:**

Requestor's Name (if the person making this request is not the person this appeal request is for)

First Name:  Last Name:  Relationship to person the appeal is for:

Street Address:

Apartment number:

City:

Zip:

Primary Phone Number:

Secondary Phone Number:

Email Address:

If a cell phone, would you like to receive text messages?  No  Yes (Data rates may apply)

Requestor's Signature:

Date:

**You must sign and date in the space above. This may be signed in ink or electronically. By typing your name, you are agreeing that you have electronically signed this form.**

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REPRESENTATIVE AUTHORIZATION

Only complete this section if you have an Authorized Representative.

I, the person this appeal is for, authorize the following person to represent me in this appeal:

First Name:  Last Name:  Relationship to person the appeal is for:

Street Address:  Apartment number:

City:  Zip:

Primary Phone Number:  Secondary Phone Number:  Email Address:

If a cell phone, would you like to receive text messages?  No  Yes (Data rates may apply)

Signature of person the appeal is for:  Date:

You must sign and date in the space above. This may be signed in ink or electronically. By typing your name, you are agreeing that you have electronically signed this form.

DATES/TIMES NOT AVAILABLE

Please write any dates and times you are not available within the next 90 days so that your informal meeting, mediation, or hearing is not scheduled during those dates and times:

\*Signature of person submitting this appeal request, or Authorized Representative:

\*Date:

You must sign and date in the space above. This may be signed in ink or electronically. By typing your name, you are agreeing that you have electronically signed this form.

Your rights during the appeal process were provided with your NOA. Those rights also are listed here: <https://www.dds.ca.gov/wp-content/uploads/2023/03/Appeal-Rights-March-2023.pdf>

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