



# Iowa Department of Human Services

Terry E. Branstad  
Governor

Kim Reynolds  
Lt. Governor

Charles M. Palmer  
Director

February 3, 2012

## GENERAL LETTER NO. 1-E-AP-11

ISSUED BY: Appeals Section

SUBJECT: Employees' Manual, Title 1, Chapter E, **APPEALS AND HEARINGS APPENDIX**, Title page, revised; page 1, revised; and the following forms:

470-0487 *Appeal and Request for Hearing*, revised  
470-0487(S) *Appeal and Request for Hearing (Spanish)*, revised

### Summary

Chapter 1-E Appendix is revised to:

- ◆ Update the instructions to reflect availability of form 470-0487, *Appeal and Request for Hearing*.
- ◆ Add a checkbox for child abuse appeals on forms 470-0487 and 470-0487(S), *Appeal and Request for Hearing*.

### Effective Date

Upon receipt.

### Material Superseded

This material replaces the following forms in Employees' Manual, Title 1, Chapter E, Appendix:

<u>Page</u>	<u>Date</u>
Title page	March 23, 2007
470-0487	4/06
470-0487(S)	4/06
1	March 23, 2007

### Additional Information

Destroy existing supplies of form 470-0487, *Appeal and Request for Hearing*. The form is no longer printed.

Refer questions about this general letter to your service area manager.

Revised February 3, 2012

Employees' Manual  
Title 1  
Chapter E Appendix

# APPEALS AND HEARINGS

## APPENDIX



Iowa Department  
of Human Services

Iowa Department of Human Services  
**Appeal and Request for Hearing**

Fill out the top part of this form. You do not need to fill out the worker information part.

Name: Last	First	Mi
Mailing Address		
City	State	Zip Code
Phone Number	County	
( )		

- Check the programs you want to appeal.
- Family Investment Program (FIP), Refugee Cash Assistance (RCA) or PROMISE JOBS
  - Child Care Assistance
  - Food Assistance
  - Medicaid including Waivers
  - Attribution
  - Administrative Hearing (only for attribution appeals)
  - Child Abuse
  - State Supplementary Assistance
  - Child Support
  - Adoption or Foster Care
  - Other (explain): \_\_\_\_\_

- I want my benefits to continue, if they can.  Yes  No  
 I want an interpreter for my hearing.  Yes  No  
 If yes, what language do you read? \_\_\_\_\_  
 I want a pre-hearing conference.  Yes  No  
 Tell us why you are appealing. Please be brief.

You may have to pay them back if you lose your appeal.  
 We will provide an interpreter for you.  
 What language do you speak? \_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

If you want someone to help you with your appeal, please write the person's name and address below. This person will get information about your appeal. **You are not required to list someone here.**

Name	Phone Number ( )		
Mailing Address	City	State	Zip Code

**Worker Information**

Worker Name		Phone Number ( )	
Worker Number	County/Office	Case Number/SID Number	

Will benefits continue or did you reinstate benefits because of this appeal?  Yes  No  
 If not, why?  Application/recertification  Appellant chose **not** to have benefits continue  
 Appeal not filed before the effective date  Other (explain) \_\_\_\_\_

If the consumer wants an interpreter, what language is needed? \_\_\_\_\_

The adverse action appealed is the result of a:  
 DDS report  IFMC decision  CSC worker action \_\_\_\_\_  
 LBP PJ worker \_\_\_\_\_ Office \_\_\_\_\_  
 QC report QC worker \_\_\_\_\_ Office \_\_\_\_\_  
 DIA investigation Investigator \_\_\_\_\_ Office \_\_\_\_\_

**Attach a copy of the NOD being appealed.** If it isn't attached, explain why: \_\_\_\_\_

Tell us your vacation and training schedule for the next 3 months. \_\_\_\_\_

## Instructions

Use of this form is not mandatory. Any written appeal is a valid appeal.

**Verbal appeals are valid only in the Food Assistance program.** The worker receiving the Food Assistance appeal should record verbal appeals on this form. Be sure to indicate that this is a verbal appeal. Also, include the date the appeal was requested.

If you get a letter stating the consumer wants to appeal, attach the letter to this form. You need to fill in the consumer's information and your information.

If you do not know what the consumer is appealing, you need to indicate what you think the appeal is about. The DHS Appeals Section will ask the consumer for additional information, if necessary. **Do not hold an appeal if you need to get additional information from the consumer.**

On the front of this form, date-stamp all appeals on the date they are received in your office. If you got the appeal in the mail, keep the postmarked envelope and attach it to this form.

Attach a copy of the Notice of Decision that the consumer appealed to this form. Send this to:

Department of Human Services  
Appeals Section, 5<sup>th</sup> Floor  
1305 E Walnut St  
Des Moines, IA 50319-0114

Send in an appeal summary to the DHS Appeals Section within 10 calendar days of the date the appeal was filed. Do not delay sending in an appeal while you work on your appeal summary.

Send all new appeals to the DHS Appeals Section within one working day of receipt. Be sure to include the Notice of Decision and the postmarked envelope, if applicable. Use local mail if available.

If the appellant requests that benefits continue, but the appellant does not meet the criteria listed in Employees' Manual 1-E, then issue a manual notice of decision stating that the appellant's request for continuation of benefits while an appeal is pending is denied. The appellant has the right to appeal this action also.

Be sure to indicate your vacation and training schedule for the next 3 months. This will be used when scheduling a hearing.

For more information about appeals, check out the Appeals Section intranet site at <http://dhsintranet/appeals/>

## Appeal and Request for Hearing (Apelación y Solicitud de Audiencia)

Complete la mitad superior de este formulario. No es necesario que llene la sección con los datos del trabajador.

Identificación: Apellidos	Primer Nombre	Segundo nombre
Dirección postal		
Ciudad	Estado	Código postal
Número de teléfono (    )	Condado	

- Marque los programas a los que desea apelar.
- Family Investment Program (Inversión familiar, FIP), Refugee Cash Assistance (Asistencia en efectivo para refugiados, RCA) o PROMISE JOBS
  - Child Care Assistance (Asistencia de cuidado infantil)
  - Food Assistance (Asistencia en alimentos)
  - Medicaid incluyendo Waivers (servicios de exención)
  - Atribución
  - Audiencia administrativa (solo para apelaciones de atribución)
  - Abuso Infantil
  - State Supplementary Assistance (Asistencia estatal complementaria)
  - Child Support (Manutención de menores)
  - Adopción o familia sustituta
  - Otro (explicar): \_\_\_\_\_

Si es posible, deseo que mis beneficios continúen.  Sí  No Si usted pierde esta apelación, es posible que deba reembolsar el costo de dichos beneficios.

Deseo la asistencia de un intérprete durante la audiencia  Sí  No Se le proporcionara la asistencia de un intérprete.

En caso afirmativo, ¿qué idioma lee usted? \_\_\_\_\_ ¿Qué idioma habla usted? \_\_\_\_\_

Deseo una conferencia previa a la audiencia.  Sí  No

¿Cuál es el motivo de su apelación? Sea breve.

Firma \_\_\_\_\_ Fecha \_\_\_\_\_

Si desea contra con la ayuda de alguna persona durante esta apelación, anote su nombre y dirección en los campos siguientes y esa persona podrá recibir información acerca del proceso. **No es obligación que designe a alguien.**

Nombre	Número de teléfono (    )		
Dirección postal	Ciudad	Estado	Código postal

### Worker Information (Información del trabajador)

Worker Name		Phone Number (    )	
Worker Number	County/Office	Case Number/SID Number	
Will benefits continue or did you reinstate benefits because of this appeal? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, why? <input type="checkbox"/> Application/recertification <input type="checkbox"/> Appellant chose <b>not</b> to have benefits continue <input type="checkbox"/> Appeal not filed before the effective date <input type="checkbox"/> Other (explain) _____			
If the consumer wants an interpreter, what language is needed? _____			
The adverse action appealed is the result of a:			
<input type="checkbox"/> DDS report	<input type="checkbox"/> IFMC decision	<input type="checkbox"/> CSC worker action _____	
<input type="checkbox"/> LBP	PJ worker _____	Office _____	
<input type="checkbox"/> Q.C. report	QC worker _____	Office _____	
<input type="checkbox"/> DIA investigation	Investigator _____	Office _____	
<b>Attach a copy of the NOD being appealed.</b> If it isn't attached, explain why: _____			
Tell us your vacation and training schedule for the next 3 months. _____			

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If you do not know what the consumer is appealing, you need to indicate what you think the appeal is about. The DHS Appeals Section will ask the consumer for additional information, if necessary. **Do not hold an appeal if you need to get additional information from the consumer.**

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If the appellant requests that benefits continue, but the appellant does not meet the criteria listed in Employees' Manual 1-E, then issue a manual notice of decision stating that the appellant's request for continuation of benefits while an appeal is pending is denied. The appellant has the right to appeal this action also.

Be sure to indicate your vacation and training schedule for the next 3 months. This will be used when scheduling a hearing.

For more information about appeals, check out the Appeals Section intranet site at <http://dhsintranet/appeals/>

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**Appeal and Request for Hearing, 470-0487 and 470-0487(S)**

Purpose	Form 470-0487 is used to initiate the appeal process and to supply information needed to proceed with an appeal.
Source	<p>Appellants may complete either the English or Spanish version of this form electronically at <a href="https://dhssecure.dhs.state.ia.us/forms/">https://dhssecure.dhs.state.ia.us/forms/</a>. The request will be submitted directly to the Appeals Section to be processed.</p> <p>Department staff may complete the English version on line using the template in the public state-approved forms folder on Outlook.</p> <p>Print supplies of the Spanish version of this form from the on-line manual.</p>
Completion	<p>The form is divided into two parts. The person wishing to appeal (the appellant) or someone acting for the appellant completes the top part to initiate the appeal. The worker should assist in completing this part of the form if the appellant wishes. A worker who receives this form from the appellant completes the worker information section.</p> <p>An appeal may be requested without completing this form. Any written appeal is valid. A request for a Food Assistance appeal may be expressed verbally or in writing.</p> <p>If the appellant requests an appeal verbally or in other written form, the worker shall complete the identifying information and attach the appeal request to the form. (The worker information section is not required for appeal requests filed directly with the Appeals Section.)</p>
Distribution	<p>If the form is submitted to the local office, make three copies of the completed form. Distribute them as follows:</p> <ul style="list-style-type: none"><li>◆ Give a copy to the appellant.</li><li>◆ Keep a copy in the case file.</li></ul>