APPEAL FORM

Appeal Request Process

You may request an appeal by doing one of the following below. If you submit this form, the state will complete a review of your case to try to resolve the issue.

- **Online.** Log into your account at www.healthyrhode.ri.gov and click on "file an appeal".
- **By phone.** You can file an appeal regarding Medicaid and Private Health Coverage through HealthSource RI by calling HealthSource RI at 1-855-840-HSRI (4774). For questions about filing an appeal for human services programs such as SNAP, RIW, Child Care, GPA, or SSP call the Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347).
- **In person.** For in-person assistance visit **www.dhs.ri.gov** to view office locations.
- **By mail**. Complete this form and mail it to ATTN: Appeals STATE OF RHODE ISLAND, P.O. BOX 8709, CRANSTON, RI 02920-8787.

Name (required): ____________________

Date of Birth (required): ____________________

Account Number: ____________________

Address (required): ____________________

Phone number: ____________________

Email: ____________________

Do you need help speaking, reading or writing English? ☐ Yes ☐ No:

If yes, what is your primary language? ____________________

Preferred method of contact (circle one): email / paper mail

You must check off the reason(s) for your appeal:

Health Coverage:	Human Services:	
______ Medicaid	______ SNAP	______ GPA
______ Private Plan - HealthSource RI	______ RIW	______ CHILD CARE
______ Both/Unsure	______ SSP	

______ Other (Please explain) ____________________

For More information visit www.healthyrhode.ri.gov
Para más información visite www.healthyrhode.ri.gov
Para mais informações visite www.healthyrhode.ri.gov

Please explain the reason for your appeal:

Do you need important health services or SNAP benefits immediately? If so, would you like an expedited appeal? ☐ Yes ☐ No:

If yes, Please explain:

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

☐ Check this box if someone is going to help you with the appeal or represent you during the appeals process. This can be an attorney, friend, or family member. Provide this person's contact information:

Name: __________

Phone: __________

Address: __________

Email: __________

Would you like your coverage and benefits to continue unchanged while you wait for a hearing decision? ☐ Yes ☐ No:

Signature __________ Date __________

(Recipient)

TO BE COMPLETED BY THE AGENCY ONLY:

APPEAL IS ABOUT: ____ RIW ____ MEDICAID ____ GPA

____ SNAP ____ PRIVATE HEALTH PLAN ____ CHILD CARE

____ OTHER

Indicate Specific Policy Manual Reference: Section(s) __________

Agency response to appeal/explanation: __________

Agency Representative (Signature) __________ Supervisor(Signature) __________

(Print Name) __________ (Print Name) __________

Local Office __________

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