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MEDICAID ELIGIBILITY  
FORMS AND INSTRUCTIONS

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DOM-351 NOTICE OF DECISION ON LOCAL HEARING

**PURPOSE & USE**

This form is used to notify the client of the decision rendered as a result of the local hearing. This form may also be used by the client to request a State-level hearing if he/she disagrees with an adverse local-level hearing.

Prepare an original and 1 copy. The original is mailed to the client or representative and the copy is filed in the case record. Refer to Section J, Hearings.

**INSTRUCTIONS**

In the space provided, enter the date the local hearing was held and the decision reached by the Regional Office staff member who conducted the hearing. The decision must include a policy statement which supports the decision, i.e., the policy pertaining to the hearing issue must be explained.

In addition, the effective date of any further action to be taken as a result of the hearing will be specified. For example, if benefits are to be reinstated, the effective date of reinstatement must be shown. If benefits have been continued pending the hearing and the hearing decision is adverse, the effective date of any reduction or termination of benefits will be shown.

Date of Mailing: Enter the date the form is mailed to the client.

Signature of Local Hearing Officer: The person who conducted the local hearing will sign here.

Mailing Address of Regional Office: Stamp the Regional Office address in this space.

A hearing pamphlet will be enclosed on all adverse hearing decisions.

NOTICE OF DECISION ON LOCAL HEARING

TO \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Case Name \_\_\_\_\_  
Medicaid ID # \_\_\_\_\_

This is to notify you of the decision reached as a result of the local hearing held \_\_\_\_\_  
\_\_\_\_\_. The decision is as follows:

If you disagree with this decision and wish to request a State hearing, we must receive your written request within 15 days from the date of mailing shown below. In order to request a State hearing you may complete the bottom portion of this form and mail it into the Regional Office at the address shown below. If we do not hear from you within 15 days from the date of mailing this form, we will know that you understand the reason for this decision on your local hearing.

\_\_\_\_\_  
Date of Mailing

\_\_\_\_\_  
Signature of Local Hearing Officer

Mailing Address of Regional Office:

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**COMPLETE THIS SECTION IF YOU WISH TO REQUEST A STATE HEARING**

I wish to request a State Hearing because I disagree with the decision reached on my local hearing.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client or Representative

Enclosure: Hearing Pamphlet