NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE
ALBANY, NEW YORK

REQUEST FOR COMPLIANCE

Fair Hearing #	_____	Agency	_____
Hearing Date	_____		
Decision Date	_____		
Case #	_____		
Name	_____	Representative	_____
Address	_____	Address	_____
City/State/Zip	_____	City/State/Zip	_____
Phone	_____	Phone	_____

If you do not feel that the local social services Agency has complied with your fair hearing decision, state the reason below and return this entire form to the address indicated below:

New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
Compliance Unit
P.O. Box 1930
Albany, NY 12201-1930

Phone: 800-342-3334
Fax: (518) 473-6735

Please be as specific as you can in describing what action has not been complied with or what benefits have not been provided -giving dollar amounts and dates where possible.

I do not feel that the local social services Agency has complied with my decision because:

_____

_____

_____

_____

_____

_____

Be sure to include your Social Security Number and a phone number where you can be reached in the space below.

_____	_____	_____	_____
Signature	Social Security Number	Phone Number	Date