

FAIR HEARING REQUEST FORM – FAX OR MAIL

P.O. BOX 1930
ALBANY, NY 12201-1930

Please Print Information Clearly. Correct and Complete Information will Permit us to Promptly Schedule a Fair Hearing

CASE NAME: _____
(LAST) (FIRST) (MI)

STREET ADDRESS: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: () _____ DATE OF BIRTH: _____ SS#: _____
AREA CODE PHONE #

MALE FEMALE CASE #: _____ CIN #: _____ LOCAL AGENCY/CENTER #: _____

INTERPRETER NEEDED? YES NO LANGUAGE: _____

Is appellant homebound? Yes No If yes, provide medical documentation. Do not delay request to obtain medical. A phone number for representative or requester is required if you don't have a phone:

Representative Requester NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE #: () _____
AREA CODE PHONE #

DID APPELLANT RECEIVE A NOTICE FROM THE LOCAL SOCIAL SERVICES DEPARTMENT? YES NO
(***** PLEASE ATTACH A COPY OF THE NOTICE WITH THIS FORM *****)

If Yes: Date of Notice: _____ Effective Date: _____ NOTICE #: _____ RTI #: _____

RESTRICTIONS Put an X in days or times you cannot attend hearing	LOCAL AGENCY ACTION	CATEGORY OF ASSISTANCE (definitions below box)						OTHER (indicate what type)
		FA	SNA	MA	FS	HEAP	PCS*	
M T W T F	Discontinuance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
AM	Reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Denial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PM	Inadequacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Must provide a reason)

* If Personal Care Services: Provide CASA # _____/Agency _____ & indicate type of services: _____

Name of Managed Care Plan _____

FA=Family Assistance (formerly ADC) SNA=Safety Net Assistance (formerly HR) MA=Medicaid
FS=Food Stamps HEAP=Home Energy Assistance Program PCS=Personal Care Services

Reason for requesting hearing (indicate time frames): _____

Information needed for Foster Care hearings: Child's name, child's date of birth, birth mother's name, child's case number, agency's name.
Need to indicate period seeking foster care payments.