

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#: _____

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 while obtaining medical. A phone number for representative or requester is required if you don't have a phone.**

Representative Requester NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ 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 #: _____

<p>RESTRICTIONS Put an X in days or times you cannot attend hearing</p> <p>M T W T F</p> <p>AM _____</p> <p>PM _____</p> <p>(Must provide a reason)</p>	LOCAL AGENCY ACTION				CATEGORY OF ASSISTANCE (definitions below box)				
		FA	SNA	MA	SNAP	HEAP	PCS*	OTHER	
	Discontinuance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
	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"/>	_____
	Inadequacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<p>* If Personal Care Services: Provide CASA # _____/Agency _____ & indicate type of service: _____</p> <p>Name of Managed Care Plan _____</p>									

FA = Family Assistance (former ADC)
MA = Medicaid

SNA = Safety Net Assistance (formerly HR)
HEAP = Home Energy Assistance Program

SNAP = Supplemental Nutrition Assistance Program (formerly Food Stamps)
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. Indicate period seeking foster care payments.