

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#: _____

This can be found at the top of your Notice of Intent or Notice of Decision.

CASE #: _____ CIN #: *Client Identification Number* 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.**

Appellant is the person whose benefits were changed.

Representative **Requester** NAME: _____

Select Requester if this form is being filled out by the person who is asking for the fair hearing to discuss their own benefits. Select Representative if your form is being filled out by a separate person who is representing the person who is requesting the fair hearing.

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 *****)**

You can leave this blank if needed

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)					<p><i>This information can be found on your Notice of Intent or Notice of Decision.</i></p>	
		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"/>		<input type="checkbox"/>
	Reduction	<input type="checkbox"/>	<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) SNA = Safety Net Assistance (formerly HR) SNAP = Supplemental Nutrition Assistance Program (formerly Food Stamps)
MA = Medicaid HEAP = Home Energy Assistance Program PCS = Personal Care Services

Reason for requesting hearing (indicate time frames):

If you are requesting that your benefits continue unchanged while you wait for your hearing decision, make that request in this space, and be sure you have requested your hearing within ten days of the date of the notice or before the effective date. If the postmark on the envelope that contained the notice is later than the date of the notice, put that information here, and upload a copy of the envelope as part of your evidence. Also, if you are in an emergency situation (no housing, no heat, no food) state that here and ask that your hearing be "expedited" (scheduled as soon as possible).

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.